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NIGERIA SAVING MOTHERS GIVING LIFE (SMGL) END-OF-PROJECT EVALUATION

November 2019

This publication was produced at the request of the United States Agency for International Development. It was prepared independently by Deborah Caro, Adedayo Adeyemi, Peter Adeyeye, Anna Afferri, Mohammed Bello, and Emilia Okon.

Cover Photo: Beneficiaries of the SMGL Project at the Primary Health Center, Idundu in Akpabuyo local government area, Cross River State, who took part in the key informant and group discussions. One of them used to be a traditional birth attendant. Credit: Anna Afferri

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ABSTRACT

The USAID Saving Mothers Giving Life program in Nigeria is a five-year activity implemented under Pathfinder's Evidence to Action Project cooperative agreement, with the goal of reducing the maternal mortality rate by 25 percent and the neonatal mortality rate by 35 percent in health facilities (HFs).

The project carried out in Cross River State, aimed to reduce the three areas of delays (3-Ds) to receiving timely and quality evidence-based and respectful obstetric and neonatal care: delay in recognizing the need to seek care and making the decision to do so; delay in reaching services; and delay in receiving timely quality care.

The evaluation focused on answering questions on access, quality of care, linkages between local government and HFs, gender integration, and sustainability.

The project increased the use of antenatal care, delivery in HFs, and contraceptive use as well as reduced maternal and neonatal deaths in HFs. It strengthened emergency obstetric and neonatal care by task shifting and strengthening capacity of health workers. The project developed community-based emergency transport and discouraged deliveries by traditional birth attendants (TBAs) by paying them to refer women to HFs. The project supported mentoring and supportive supervision through the engagement of retired midwives and volunteers from professional medical associations.

Recommendations include:

- Decrease dependence on TBA cash payments.
- Build capacity in state government to manage interventions that address the 3-Ds.
- Continue trainings, mentoring, and supportive supervision.
- Pay greater attention to gender equality from project design through implementation.
- Strengthen local government's capacity to raise revenue in support of reducing the 3-Ds.

ACKNOWLEDGMENTS

Everywhere the evaluation team went over the course of the evaluation, we were met with enthusiasm about the project. Health workers felt empowered by new skills they had acquired and the contribution they now make to saving the lives of mothers and babies. Similarly, community members, both men and women, and their leaders expressed appreciation for improvements in the health system and their own knowledge about the causes of maternal and neonatal deaths, which now stimulate them to seek care from skilled providers in a timely fashion. They expressed their pride as ward committee members for supporting emergency transport drivers, or as traditional birth attendants who now refer women to the health services instead of trying to deliver them at home. We would like to thank all of those who took the time to speak to us and share their experiences, especially the Community Health Extension Workers (CHEWs), nurses, and doctors, as well as ward committee members, emergency transport system drivers, women who had delivered in the last year and their partners, and the mentor midwives who provided supportive supervision to CHEWs, in the local government areas (LGAs) of Akpabuyu, Calabar, Ikom, Ogoja, and Yakurr. They all helped us see both the magnitude of change and continuing challenges.

In Calabar, we would like to extend our thanks to senior leadership in the Cross River State Ministry of Health, including the permanent secretary, Dr. Joseph Bassey, and the former director, Dr. Inyang Asibong, who came to talk to us during her vacation. We are also grateful to Dr. Edu Betta, commissioner of the Cross River State Primary Health Care Development Agency, who fit us into her busy day among rehearsals for the inauguration of the governor. We also would like to thank the technical staff in safe motherhood, reproductive health, community social mobilization, and monitoring and evaluation (M&E) whom we spoke to at both agencies.

Additionally, we greatly benefited from the insights of Dr. Mabel Ekott, coordinator of the Cross River State (CRS) chapter of Society of Gynecology and Obstetrics of Nigeria, Drs. Emmanuel Adams, CRS, and Dr. Chigozie Nzomba—national coordinators of Nigerian Society of Neonatal Medicine, and Dr. Dan Abubaker from Association of General and Private Medical Practitioners of Nigeria. Dr. Samuel Oyeneiyi, assistant director of the Reproductive Health Division and coordinator of the Maternal Perinatal Death Surveillance Response (MPDSR) at the Nigerian Federal Ministry of Health (FMOH) generously provided information related to the MPDSR, and his supervisor Dr. Kayode Afolabe, director of Reproductive Health Division of the FMOH was helpful in placing the Saving Mothers Giving Life (SMGL) project into the wider context of maternal and neonatal health efforts in the country.

Due to delays in the timing of the evaluation, we arrived at the project a month before it was scheduled to close. Consequently, many staff were either very busy with end-of-project activities, or on vacation. Nevertheless, they very generously gave of their time to help us understand the intricacies of a very complex project. We would especially like to thank Dr. Farouk Jega, SMGL chief of party and Pathfinder country director; Yemisi Femi-Pius, program manager; Yemisi Erhunmwunse, senior M&E technical advisor, and Jaiyeola Olayiwola, senior technical manager. A special thanks goes to Kazeem Arogundade and Eberechukwu Eke who magically pulled together meetings for us in primary healthcare centers, communities, and hospitals in five LGAs, and with health authorities in Calabar at lightning speed. We are extremely grateful.

Finally, we would like to thank all at USAID who guided the evaluation and gave us insights into the SMGL experience in Nigeria and in Zambia and Uganda. We are grateful to Claudia Morrissey Conlon, who was the former USAID/Global Health Senior Maternal and Newborn Health Advisor and United States Government lead for SMGL in the three programming countries, who provided background and context. We also would like to thank Amobi Onovo, M&E specialist at USAID Nigeria guided the evaluation. Gertrude Odezugo, senior reproductive health manager; SMGL activity manager; and Vathani Amirthanayagam at the USAID Nigeria Mission, who provided background information and articulated priorities for the evaluation and provided probing comments on the draft report. We thank all of them for their valuable input.

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ACRONYMS

3-Ds	Three Areas of Delays
AGPMPN	Association of General and Private Medical Practitioners of Nigeria
ANC	Antenatal Care
BEmONC	Basic Emergency Obstetric Neonatal Care
CBO	Community-Based Organization
CEmONC	Comprehensive Emergency Obstetric Neonatal Care
CHEDRES	Center for Healthworks, Development, and Research
CHEW	Community Health Extension Worker
CRS	Cross River State
CRS MOH	Cross River State Ministry of Health
CRS PHCDA	Cross River State Primary Health Care Development Agency
E2A	Evidence to Action Project
EmONC	Emergency Obstetric Neonatal Care
ENC	Essential Newborn Care
ETS	Emergency Transport System
FMOH	Nigerian Federal Ministry of Health
FP	Family Planning
FTP	First Time Parents
GHF	Greater Hands Foundation
GHI	Greater Hands Initiative
HF	Health Facility
KII	Key Informant Interview
LARC	Long-Acting Reversible Contraceptive
LGA	Local Government Area
M&E	Monitoring and Evaluation
M4M	Merck for Mothers
MEL	Monitoring, Evaluation, and Learning
MICS	Multiple Indicator Cluster Surveys
MMR	Maternal Mortality Ratio
MNH	Maternal and Neonatal Health
MNCH	Maternal, Neonatal, and Child Health
MOH	Ministry of Health
MPDSR	Maternal Perinatal Death Surveillance Response

MSC	Most Significant Change
MSF	Monthly Summary Form
NDHS	Nigeria Demographic and Health Survey
NGO	Non-Governmental Organization
NISONM	Nigerian Society of Neonatal Medicine
NMR	Neonatal Mortality Rate
PPC	Postpartum Care
PPFP	Postpartum Family Planning
PPMV	Patent and Proprietary Medicine Vendor
RH	Reproductive Health
RMNCH	Reproductive, Maternal, Neonatal, and Child Health
RMNH	Reproductive, Maternal, and Neonatal Health
SBA	Skilled Birth Attendant
SMGL	Saving Mothers Giving Life
SOGON	Society of Gynecology and Obstetrics of Nigeria
SOML	Saving One Million Lives
SPHCDA	State Primary Health Care Development Agency
TBA	Traditional Birth Attendant
USAID	United States Agency for International Development
WDC	Ward Development Committee
WHO	World Health Organization

EXECUTIVE SUMMARY

EVALUATION PURPOSE AND EVALUATION QUESTIONS

The purpose of this endline evaluation is to provide the United States Agency for International Development (USAID) with a summative assessment of Saving Mothers Giving Life (SMGL) program implementation and measurable results in Nigeria.

The audience for the evaluation is USAID in Nigeria and other SMGL stakeholders, such as the USAID Bureau of Global Health, Nigerian Federal Ministry of Health (FMOH), the Cross River State Ministry of Health (CRS MOH) and the Cross River State Primary Health Care Development Agency (CRS PHCDA), who requested that the evaluation team respond to the five critical questions:

1. To what extent has access to and utilization of evidence-based, high quality [reproductive, maternal, neonatal, and child health] RMNCH interventions changed in SMGL-supported areas in Cross River State [CRS]?
2. How has project implementation and its mode of delivery changed quality of service delivery of maternal and newborn health interventions and comprehensive family planning [FP] services?
3. To what extent have community structures contributed to changes in demand for, access to, and utilization of quality health delivery services in the targeted communities?
4. To what extent has SMGL incorporated gender strategies to improve accessibility and utilization of services?
5. To what extent have state and local authorities made plans to sustain SMGL's interventions and activities in CRS?

PROJECT BACKGROUND

The USAID SMGL initiative is a five-year, centrally managed activity, implemented in Nigeria under the Evidence to Action Project (E2A) cooperative agreement with a $16 million ceiling, under award number AID-OAA-A-11-00024. Despite sizable investments by donors and aggressive efforts by the government to reduce maternal and neonatal mortality, the measures for maternal mortality ratio (MMR) and neonatal mortality rate (NMR) remain uncharacteristically high for a country of Nigeria's gross domestic product (GDP) and health system development. The project is linked to a promising approach piloted in Uganda and Zambia designed to reduce the three areas of delays (3-Ds) to receiving timely and quality evidence-based and respectful obstetric and neonatal care.

Despite continuous efforts to improve maternal, neonatal, and child health (MNCH) outcomes in Nigeria, some relevant MNCH indicators remain poor. According to the 2013 Nigeria Demographic and Health Survey (NDHS), which was just prior to inception of the project in the last quarter of calendar year 2014, the MMR for the country was 576 per 100,000 live births and the NMR is reported as 37 per 1,000 live births. The project entailed addressing sociocultural and economic barriers to women making timely decisions to seek care (delay 1). It also invested in reducing constraints to reaching care, by organizing availability of free 24-hour/day transport and upgrading health facilities (HFs) located within no more than two hours' distance for women to reach care (delay 2). Additionally, the project addressed the quality of timely evidence-based care (delay 3) that women and their babies are able to

receive by a skilled birth attendant (SBA) for both normal deliveries and emergencies at the appropriate level of care within the health system.

EVALUATION DESIGN, METHODS, AND LIMITATIONS

A team of consultants implemented an evaluation of the SMGL in CRS from May 8 to June 28, 2019. The initial phase of the evaluation entailed document review and planning. The second phase focused on data collection through key informant interviews (KIIs) and group interviews in the project areas of CRS. A third phase encompassed data synthesis, analysis, and interpretation to serve as input into the evaluation report.

The people interviewed included a wide variety of stakeholders, such as Pathfinder staff, HFs, CRS MOH, and CRS PHCDA; medical bodies, and the FMOH. The team used a mixed methods approach with triangulated analyses to address each of the five evaluation questions.

The evaluation methodology involved desk reviews of key SMGL project documents (plans, indicator reference guides, reports), KIIs with federal and CRS healthcare officials, healthcare facility administrators, Pathfinder managers, and other SMGL implementing partners. The team conducted group interviews with Basic Emergency Obstetric Neonatal Care (BEmONC) and Comprehensive Emergency Obstetric Neonatal Care (CEmONC) healthcare providers, ward development committee (WDC) members, emergency transport system (ETS) drivers, traditional birth attendants (TBAs), women who had given birth in the last year and their partners, and older women whose daughters or daughters-in-law had given birth in the last year. The evaluation team interviewed more than 250 individuals in all and visited approximately 20 percent of the HFs supported by the SMGL.

FINDINGS

Access: The first section of the findings analyzes critical changes in demand as they relate to access and utilization of MNCH services. The findings reveal the extent to which key access barriers that result in delays in seeking care (delay 1) and arriving at evidence-based obstetric and neonatal care HFs (delay 2) have been reduced. Community outreach activities served as the entry point for educating women and the larger community on the importance of visiting HFs for RMNCH needs. Three community-based organizations (CBOs), one per senatorial district, were primarily assigned to work in all the communities within the radius of the 108 intervention facilities and conduct grassroots mobilization to educate the populace on the importance of using the HFs for antenatal care (ANC), labor and delivery, and postpartum care (PPC), and FP. Their coverage was enhanced by the deployment of medical volunteers recruited by the CBOs and trained by SMGL to do home visits, facility referrals, and organize community outreach. The qualitative observations from the study showed high presence of Community Health Extension Workers (CHEWs) across all facilities visited, accounting for increased engagement with women at the community level through home visits and community outreach for facility referrals, forming an essential part of CHEWs's role.

In addition, innovations such as ETS supported by WDCs and training of ETS drivers and TBAs on obstetric danger signs appeared to significantly reduce delays 1 and 2. Project monitoring data indicate that both the number of women with four ANC visits and the number of women delivering in an HF

have increased two-fold. Both numbers superseded the indicator targets. The monitoring data also demonstrate that the number of HF deliveries quadrupled in HFs supported by SMGL.[1]

Quality of Care: The second section of the findings aims to provide an overview of changes in the quality of services during the implementation of SMGL. It describes and assesses the tripartite model of quality improvement that includes capacity building on evidence-based practices, supportive supervision, and mentoring. In addition, in the last six months of the initiative, SMGL introduced an accountability procedure based on the Nigerian national health policy for Maternal Perinatal Death Surveillance Response (MPDSR) for quality improvement. The MPDSR stipulates that each maternal and neonatal death, as well as near misses, be reviewed and that adjustments be made to rectify any lapse in evidence-based practice that contributed to the death or near miss.

SMGL strengthened the capacity of health workers through multiple rounds of trainings and refresher trainings delivered in collaboration with the CRS MOH and the CRS PHCDA. The facilitators used a variety of tools, including manikins and medical equipment to simulate real-life emergencies. The upgrading of skills; mentoring and supportive supervision; increased rigor in registration, reporting, analysis, and use of health information; and auditing of deaths have contributed to notable reductions in maternal and neonatal deaths in HFs in CRS. Both health workers and community members are aware of these changes and the evidence of fewer deaths has contributed to health workers' pride in and commitment to their work and increased satisfaction with and use of health services.

Community and Local Government Linkages to HFs: This final section of the findings analysis examines the character and strength of linkages between community organizations and government with HFs. SMGL worked with local organizations to address constraints that affected delays 1 and 2. Interventions and outreach to pregnant women, their male partners, local chiefs, e committe members, and TBAs stimulated community leaders to support and facilitate the use of HFs by pregnant women. WDCs played a role as financers of the ETS, organizers of outreach activities by health workers and non-governmental organizations (NGOs), and local policy makers who passed local ordinances discouraging unskilled providers from delivering babies in their homes and churches. ETS drivers were paid to transport women to HFs for delivery at the local health center and, when needed, to provide referrals to hospitals. The project paid TBAs to refer women for delivery at the health center. While these interventions were successful in the short term in generating demand, the evaluators found that many people had concerns about their sustainability.

Gender Integration: The fourth section of the findings inquired into the degree to which the project had addressed gender inequalities. SMGL had aimed to integrate gender into its design and approaches in response to findings from the First Time Parents (FTP) Study (E2A 2018). The study revealed the importance of engaging male partners for eliminating delay 1. Despite the training and limited FTP intervention, it was difficult to find a clear gender approach or strategy for the SMGL. Lacking gender-specific indicators and a clear strategy, project documents did a poor job of reporting on gender outcomes. Nevertheless, during the field visits, the evaluation team also noticed some changes in the

[1] The evaluation team compared Q3 ANC 4 visits in FY2016 (baseline year) with Q2 ANC 4 visits for FY2017, FY2018, and FY2019 (endline year). The reason for calculating increases using one quarter per year is that both the baseline and end years only had data for two quarters each, for the last two quarters in FY2016 and for the first two quarters of FY2019. In examining the numbers from FY2017 and FY2018, it was evident that more visits occurred proportionally in the last two quarters than in the first two quarters (about 45 percent in the first two quarters and 55 percent in the last two quarters each year).

men as regards to supporting their partners' access to ANC and giving birth at the facility, though the team struggled to understand the dynamics of joint decisions in accessing FP services.

Sustainability of SMGL Achievements and Commitment and Capacity of CRS Government to the SMGL Model: This final section of the findings examines sustainability and the capacity of the CRS government to implement and manage the activities supported by SMGL to continue improvements in maternal and neonatal health (MNH) outcomes. Interviews with different stakeholder groups indicated that the parts of the SMGL initiative likely to perdure are those that have an institutional home. These include mentoring of doctors and nurses at hospitals through an agreement with the federal teaching hospital in Calabar; cascade training by CRS master trainers; WDC support for ETS; and data collection and reporting by HFs through monthly meetings facilitated by the local government area (LGA) monitoring and evaluation (M&E) officer. Payments to TBAs to refer women to HF, distribution of delivery kits (Mama Kits) to new mothers, and a digital text messaging service to encourage women to engage in healthy practices (HelloMAMA) appear to be less likely to continue unless the CRS MOH is successful in obtaining support from the World Bank Saving One Million Lives (SOML) project. Leadership of the CRS MOH and the CRS PHCDA indicated that the most challenging part to take over from Pathfinder is the integrated management of the different components of the project, which span the spectrum from community activities to engaging private and public sector hospitals.

CONCLUSIONS

The evidence from interviews, monitoring data, and comparison of baseline and endline data on the Health Facility Assessment supports the view given by virtually all the stakeholders that SMGL was a successful initiative that greatly improved access and quality of care, and reduced maternal and neonatal deaths. The expansion to 108 facilities that qualify either as BEmONC or CEmONC facilities is one of the great achievements of the project. Prior to SMGL, there were no BEmONC facilities and only one CEmONC that met the World Health Organization (WHO) criteria for appropriate signal functions in the entire CRS. Yet, it is also important to highlight that not all the PHCs and CEmONC facilities supported by SMGL strictly meet the classification of CEmONC today, even though the capability to perform the signal functions (which all have) is a necessary prerequisite to reduce maternal and neonatal deaths from direct obstetric and neonatal causes.

The evaluation concluded that a large and complex set of interventions applied simultaneously and competently were associated with measurable and impressive improvements in health outcomes for mothers and babies in the communities with access to the HFs supported by SMGL. Pathfinder managed SMGL well, which was not an easy task, given the complexity of the endeavor, the multiple actors involved in implementation, and the large and varied number of stakeholders.

The major challenge is how well the SMGL model can be implemented by the CRS government health agencies, as it will be challenging to continue the level of integration and oversight provided by Pathfinder. Discussions with the CRS MOH and CRS PHCDA raised concerns about the availability of sufficient resources and how they may be used. While the technical staff of both agencies have been intimately involved as master trainers and as supportive supervisors, there has not been a parallel set of actors from the CRS health sector engaged in the day-to-day management of SMGL.

A major consideration for USAID, moving forward, is to reconsider at this point its decision to end funding without sufficient time and mentoring for a smooth and sustainable transition. It would also be useful to have more population-based data on CRS to understand the full effect of the program, as was done in the other two SMGL countries. It is evident that the model is effective—i.e., the concept has

been proven. The questions are whether it can be implemented at scale by local and state governments, and if donors are willing to invest in a longer-term process in support of scale-up and sustainability?

The major lessons learned from SMGL are:

- It is possible to reduce MMR and NMR within a short period of time with adequate resources and skilled staff, but the results should not be assumed to be sustainable within a short-time horizon.
- Reducing MMR and NMR requires a health systems approach with integrated and interconnected interventions from the household to the MOH policy level.
- The model requires highly experienced and competent management, with multiple layers of supportive supervision, training, mentorship, and sustainable financing mechanisms.
- The model is costly and labor-intensive, and therefore requires adequate levels of financing and long implementation horizons to be sustainable.

RECOMMENDATIONS

- The HF should include TBAs in their monthly meetings/activities to continue their involvement and sensitization, and to highlight their importance as part of the wellness of the communities. Part of the revenues from the HF's cost recovery could be used as a "token" for the TBAs. Alternatively, the system SMGL has put in place to sustain the ETS could also be applied to the TBAs.
- Instead of focusing on delivery kits, moving forward the CRS MOH should focus more on adequately preparing parents for childbirth by making plans on how to respond if complications or unexpected adverse events occur; birth preparedness is a much more effective way to educate women before the delivery and should be reinforced all along the pregnancy, during ANC visits, and in community sensitizations. Some suggestions include:
    - Use of a pictorial birth-planning card in which a "*purchase calendar*" lists the items to be acquired in preparation for the birth. During outreach activities and ANC visits, the health workers check the completeness of the card.
    - Promotions of savings or income generation for small emergency funds at the family level.[2] To be effective, birth preparedness needs the involvement of men and the promotion of behaviors supportive of women's decision-making or joint decision-making.
- Ensure that the transition plan includes resources for refresher trainings and supportive supervision as needed to maintain the health workers' skills in low-volume delivery facilities; a policy on human resources retention would play an important role in a facility with a high turnover of institutional deliveries.
- Continue emphasis on the use of the partograph for all births. It is an effective tool to prevent prolonged labor, to reduce operative intervention, and to improve neonatal outcomes. The use of the partograph is affected by time constraints suffered by overburdened staff as it is a time-

[2] World Health Organization, "Birth and Emergency Preparedness in Antenatal Care," accessed 26 Nov. 2019, https://www.who.int/reproductivehealth/publications/maternal_perinatal_health/emergency_preparedness_antenatal_care.pdf.

consuming procedure. Therefore, appropriate staffing levels are needed to get full benefit out of the partograph. In high-volume facilities with an inadequate number of staff, the completion of the partograph could be challenging unless the number of health workers is increased.

- It is recommended that future MNH focus greater attention on postpartum sepsis, which increased from baseline to endline as a cause of maternal deaths. Specifically, there is a need for setting a 100 percent target for postpartum visits within 7 to 10 days postpartum to monitor both women and their newborns. Junior CHEWs, who are primarily in charge of community outreach activities, should conduct these visits and refer any woman or baby experiencing postpartum complications. Expanding home visits, outreach activities, and sensitization messages starting from ANC visits should be an asset in any program targeting the reduction of maternal deaths.

- Additional research is needed to determine the causes of the increased proportion of deaths due to postpartum sepsis. Despite improvements in the facility infrastructure in SMGL-supported HFs, access to water and electricity presented challenges for disinfecting instruments and handwashing. The research should investigate whether this is a contributory factor. The research should also investigate if increased demand for labor and delivery care has pressured health workers to discharge women who have delivered before conducting a thorough postpartum exam prior to allowing women to leave the facility, without checking for other risk factors for infection, such as manual removal of the placenta, sutures, perineal tears, or cesarean sections.

- Ensure access to safe water systems, at least in maternity wards and delivery rooms (water tanks and provision of piped water) should be contemplated in projects that invest in infrastructure renovations. A sustainable source of electricity is also needed for lighting and proper refrigeration of oxytocin and other drugs requiring a cold chain.

- Future interventions should look at exploring synergy with existing state initiatives for possible integration of community actors—particularly WDCs—as a way of making them economically viable to sustain their activities of promoting increased demand for, access to, and utilization of quality healthcare services for MNCH.

- CRS MOH should provide support for a driver and fuel for all donated emergency transport. The governor's donated tricycle ambulances came without a line item to pay a driver. ETS drivers use their own vehicles and are not available to drive car or tricycle ambulances.

- A future intervention should consider long-term income-generating activities initiatives for TBAs engaged on future programs. The majority of the TBAs on the SMGL intervention who have expressed worries on sustainable means of livelihood have not agreed to stop accepting deliveries as TBAs, but, instead, to support increased demand for, access to, and utilization of HFs by pregnant women in the communities.

- As Patent and Proprietary Medicine Vendors (PPMVs) continued to provide harmful advice and medicines to pregnant women, future interventions should engage with them more directly, perhaps including them in some of the private sector initiatives that benefited private clinics and hospitals. The illegal activities of PPMVs were reported by the TBAs as sabotaging efforts of the TBAs in promoting increased demand for, access to, and utilization of HFs for quality healthcare.

They could play a more productive role in also referring women who seek their advice and remedies to the HFs. They might also be enlisted for community distribution of contraceptives, such as condoms and pills.

- Mainstreaming gender into the project should start at the design stage with specific gender baseline data collated and a gender strategy developed as an integral part of the project, including the development of gender indicators. MNCH projects require gender integration in the project monitoring, evaluation, and learning (MEL) plan just like other types of activities. In the future, project MEL plans for health projects should include reporting on qualitative and quantitative indicators for outputs and outcomes that measure changes in gender roles and norms (beliefs and practices), and access and control over assets and information, norms, and relations of power.

- In the future, the gender position should not be the position cut from the project to save money as gender integration is required in all USAID projects. Rather, resources for gender integration should be fully allocated, especially when gender-based constraints are identified as a key barrier to delays 1, 2, and 3. The idea of allocation of the right resources—human and financial—to gender-related components and projects cannot be over-emphasized. Funds should be allocated for hiring a gender specialist or a program officer with some gender expertise and the appropriate amount of level-of-effort to do his or her job.

- Gender training should be more practical and hands-on for both project implementers and healthcare providers. It should also be adapted to local contexts as gender relations are not identical across different contexts. For example, all examples in the training curriculum should be based on gender relations in different rural ethnic groups within the project area.

- When projects like FTP are concluded, there should be a way to gather key data elements for future programming. A qualitative or quantitative baseline and endline is needed to document changes in beliefs and practices related to men's and women's roles and decision-making.

- If there are expectations that an integrated model like SMGL will be transitioned in its entirety to local and state governments, it is recommended that those stakeholders and decision-makers are involved from the design stage and have a continuing role in management throughout the project. That can be accomplished in a variety of ways, including naming government counterparts to senior leadership on the project. Similar pairing is recommended for technical staff. Over time, the onus of leadership and management can gradually shift from project personnel to government counterparts. An alternative approach would be to begin joint transition planning from the first day of the project with delineation of a series of transition benchmarks for which responsibility would move from the implementing partner to the government at strategic points in implantation up to a final year where the government assumes responsibility for the implementation and the implementing partner is available as an advisor.

- Incentive structures should be well thought out, analyzed carefully for adverse consequences, and used only temporarily with the idea of transitioning them to more sustainable solutions during project implementation, not at the end. This will allow implementing partners to problem-solve and fine-tune solutions that do not work effectively. For instance, if SMGL had used escorting stipends as a short-term measure to capitalizing alternative businesses or training

for TBAs, the ending of the stipends would not have been so abrupt and potentially threatening to a major accomplishment of the project.

- USAID and other donors should learn from the SMGL experience, as well as other successful efforts to reduce MMR and NMR. The major lessons are:
    - Envision a longer time horizon and higher resource requirements than are necessary for other health interventions, such as FP or child health, that don't require costly health interventions like surgery and blood transfusion, or transport services.
    - Eliminate the unpredictable, time-consuming, and sometimes challenging process of building local and state ownership and do it in a way that all involved feel like equal partners.
    - Invest in measuring outcomes at the individual and group (e.g., gender), facility, and population levels to better understand the dynamics of change and what factors contribute to changes in outcomes. Include resources for data collection, analysis, and group learning.
    - Invest only in training that is supported by hands-on mentoring and supportive supervision, with mechanisms for refreshing and updating skills of previously trained health workers and transferring skills to new health workers.
    - Establish a digital environment to encourage data use for decision-making. Make greater use of tablets for data collection and analysis, as well as mobile technology for communication between healthcare providers and clients, and among healthcare providers at different levels of the health system.

I. INTRODUCTION

EVALUATION PURPOSE

The purpose of this endline evaluation is to provide the United States Agency for International Development (USAID)/Nigeria with a summative assessment of Saving Mothers Giving Life (SMGL) program implementation and measurable results in Nigeria.

Specifically, this endline evaluation is being conducted to:

- Assess whether SMGL has achieved its objectives and expected outputs as stated in the SMGL negotiated program description.
- Highlight lessons learned on project implementation that address quality of service delivery of maternal and newborn health interventions, institutional delivery services, and comprehensive family planning (FP) services.
- Understand successes of implementation across the public and private health facilities (HFs) in Cross River State (CRS).
- Provide recommendations to USAID for potential future investments in strategies and/or interventions that will contribute to increasing coverage and quality of maternal, newborn, and reproductive health services in public, private, and faith-based facilities.

The audience for the evaluation is USAID in Nigeria and other SMGL stakeholders, such as the USAID Bureau of Global Health, Nigerian Federal Ministry of Health (FMOH), the Cross River State Ministry of Health (CRS MOH) and the Cross River State Primary Health Care Development Agency (CRS PHCDA), who requested the evaluation team respond to five critical questions:

EVALUATION QUESTIONS

1. To what extent has access to and utilization of evidence-based, high quality reproductive, maternal, neonatal, and child health (RMNCH) interventions changed in SMGL-supported areas in CRS?
2. How has project implementation and its mode of delivery changed quality of service delivery of maternal and newborn health interventions and comprehensive FP services?
3. To what extent have community structures contributed to changes in demand for, access to, and utilization of quality health delivery services in the targeted communities?
4. To what extent has SMGL incorporated gender strategies to improve accessibility and utilization of services?
5. To what extent have state and local authorities made plans to sustain SMGL's interventions and activities in CRS?

II. PROJECT BACKGROUND

Despite continuous efforts to improve maternal, neonatal, and child health (MNCH) outcomes in Nigeria, some relevant MNCH indicators remain poor. According to the 2013 Nigeria Demographic and Health Survey (NDHS), the maternal mortality ratio (MMR) for the country was 576 per 100,000 live births and the neonatal mortality rate (NMR) is reported as 37 per 1,000 live births, prior to the inception of the SMGL at the end of 2014. A population-based measure of MMR was not available for CRS or for the South-South Region to which it belongs for either period preceding the project. It was estimated that in 2013, 40.4 percent of births in CRS took place in an HF, which was only slightly higher than for Nigeria as a whole. Between 2013 and 2018 (see Table 1), however, there was a 12 percentage-point increase in facility-based births (to 52.6 percent), which was three times the increase at the national level (from 35.4 percent to 39.4 percent). A similar comparison is observable between the modern contraceptive prevalence rate in CRS, which rose during this period. Reasons for not delivering in a facility in 2013 included high costs of services, lack of transportation, baby born too quickly, long distances from HFs, and the perception that it was not necessary. These health concerns were possibly further exacerbated by poor quality of care at HFs, and religious beliefs that in CRS led some women to deliver in churches or with the help of other unskilled/semi-skilled providers who put women at risk of losing their lives. In 2013, 20 percent of births were delivered with traditional birth attendants (TBAs).

Table 1. NDHS Comparison of Key Indicators in 2013 and 2018

Indicators	CRS 2013	Nigeria 2013	CRS 2018	Nigeria 2018
Modern Contraceptive Prevalence Rate	14.4 %	9.8 %	18.9 %	12%
MMR	N/A*	576/100,000 live births	N/A*	512/100,000 live births**
NMR	NA (South-South = 32/1000)	37/1000 live births	N/A*	38/1000 live births
Antenatal Care [ANC] (at least 1 visit)			79.5.	67
ANC (at least 4 visits)			65.7	56.8
Delivery in an HF	40.4	35.8	52.6	39.4

* N/A = Not available

** MMR was not disaggregated to the regional or state level.

The USAID SMGL program is a five-year, centrally managed activity, implemented in Nigeria under the Evidence to Action Project (E2A) cooperative agreement with a $16 million ceiling, under award number AID-OAA-A-11-00024. The program is implemented by Pathfinder International with the goal of reducing MMR by 25 percent and NMR by 35 percent in HFs.[3]

[3] The SMGL Nigeria Endline Report (Pathfinder 2019), following the revised Monitoring, Evaluation, and Learning (MEL) plan in August 2018, states that these goals applied to facility-based births, SMGL in all three countries committed to demonstrating impressive reductions (25 to 40 percent) in MMR and NMR as population-based measures. The original goal for Nigeria was a 10 percent decrease in MMR. Halfway through the project the target was increased to 25 percent for MMR and 35 percent for NMR but only in HFs. In Zambia and Uganda, MMR was measured at the population level before and after the project. In

SMGL was part of a three-country initiative (Nigeria, Uganda, and Zambia) that aimed to reduce the three areas of delays (3-Ds) to receiving timely and quality evidence-based and respectful obstetric and neonatal care—delay in recognizing the need to seek care and making the decision to do so, delay in reaching services, and delay in receiving timely quality care. The project entailed addressing socio-cultural and economic barriers to women making timely decisions to seek care (delay 1). It also invested in reducing constraints to reaching care, by organizing availability of free 24-hour/day transport and upgrading HFs located within no more than two hours' distance for women to reach care (delay 2). The project addressed the quality of care, which poses the third delay, that of women and their babies being able to receive timely evidence-based care by a skilled attendant for both normal deliveries and emergencies at the appropriate level of care within the health system (delay 3).

The 3-Ds model proposes that pregnancy-related mortality is overwhelmingly due to delays in:

- Deciding to seek appropriate medical help for an obstetric emergency
- Reaching an appropriate obstetric facility
- Receiving adequate care when a facility is reached

The goal of SMGL/Nigeria is to accelerate reductions in maternal and neonatal morbidity and mortality in CRS (reduce MMR by 25 percent and NMR by 35 percent by 2019). USAID selected the SMGL program to support the following activity objectives:

- Increase timely utilization of institutional delivery and FP services by reducing social, economic, and geographic barriers to care-seeking.
- Improve the quality of maternity care, institutional delivery services—including emergency obstetric and neonatal care (EmONC)—and FP services.
- Ensure women and their newborns are provided key health services in an integrated manner, including the use of life-saving innovations and FP services and improving linkages and referrals between private and public-sector providers using a total market approach.
- Strengthen the capacity of health systems to capture, evaluate, and report on birth outcomes using community and facility health information systems and advocate for more state resources for sustainable FP/RH and Adolescent and Youth Sexual and Reproductive Health programs.

DEVELOPMENT HYPOTHESIS

In 2014, Pathfinder International, through E2A, began implementing the SMGL initiative across all 18 local government areas (LGAs) in CRS. Working with 108 facilities (78 public facilities and 30 private facilities), the initiative seeks to address the 3-Ds. (Note: USAID funds support work in the public and faith-based facilities, while funding for support to private HFs is received from Merck for Mothers, a partner on the SMGL Initiative.)

The SMGL project hypothesizes that **IF** it intervenes in the 3-Ds, **THEN** there will be considerable reduction in maternal and child mortality. In addition, the initiative hypothesizes that **IF** it works to

Nigeria that was not possible, and instead, the project measured MMR and infant mortality ratio at 812 public and private facilities in CRS. While the changes far surpassed the original population-based goals, they should not be viewed as equivalent to what was achieved in the other countries.

increase contraceptive prevalence, and reduce the unmet need for long-acting reversible contraceptives (LARCs), **THEN** there will be an improvement in maternal and newborn outcomes.

CRITICAL ASSUMPTIONS

The project postulated that the success in achieving the intended results is dependent upon the following critical assumptions:

- Timely disbursement of obligated funds by USAID
- Politically stable and conflict-free programming in CRS and the country at large
- Professionally stable and industrial/strike-free programming environments, and cooperation of relevant stakeholders
- Favorable environmental and weather-related conditions, such as storms, floods, and erosion that have been known to impede travel and day-to-day activities.
- Continuous political will by all levels of government (national, state, and local) to continue to support MNCH and other related public health programs.

III. EVALUATION METHODS AND LIMITATIONS

METHODOLOGY

A team of consultants implemented an evaluation of the SMGL in CRS from May 8 to June 28, 2019. The initial phase of the evaluation entailed document review and planning. The second phase focused on data collection through key informant interviews (KIIs) and group interviews in the project areas of CRS (see Tables 2 and 3). A third phase encompassed data synthesis, analysis, and interpretation to serve as input into the evaluation report.

The study population involved stakeholders, such as staff of Pathfinder, HFs, CRS MOH, and CRS PHCDA; medical bodies; and the FMOH. The team used a mixed methods approach with triangulated analyses to address each of the five evaluation questions.

The evaluation methodology involved desk reviews of key SMGL project documents (plans, indicator reference guides, reports), KIIs with federal and CRS healthcare officials, HF administrators, Pathfinder managers, and other SMGL implementing partners. The team conducted group interviews with Basic Emergency Obstetric Neonatal Care (BEmONC) and Comprehensive Emergency Obstetric Neonatal Care (CEmONC) healthcare providers, Ward Development Committee (WDC) members, emergency transport system (ETS) drivers, TBAs, women who had given birth in the last year, their partners, and older women whose daughters or daughters-in-law had given birth in the last year.

Table 2. Number of KIIs Conducted

Organization	No. of People
CRS MOH	7
Community-based organizations (CBOs): Greater Hands Foundation (GHF) and the Center for Healthworks, Development, and Research (CHEDRES)	2
Medical Associations (Society of Gynecology and Obstetrics of Nigeria [SOGON], Nigerian Society of Neonatal Medicine [NISONM], and Association of General and Private Medical Practitioners of Nigeria [AGPMPN])	4
CRS PHCDA	8
FMOH	2

Table 3. Number of Group Interviews Conducted

Group Interviews[4]	No.
Women who delivered in the last year	4
Partners of group delivered in the last year	3
Older women	3
Public PHC-BEmONC staff groups and individuals	11
Private CEmONC centers	3
WDC	4
ETS Drivers	4
TBAs	4
Public CEmONC Centers	4
Faith-based CEmONC Centers	2

Qualitative methods and data analysis

The evaluation team used interview guides tailored to each group to conduct the group interviews. The English language guides were orally translated into Efik or Pidgin, according to some groups' preferences in different locations throughout the three senatorial districts in CRS. Similarly, the team developed interview guides for the KIIs, which were conducted in English. Questions in both the group interview and KII guides were designed to answer the evaluation questions.

In addition, the most significant change (MSC) approach was adapted for use with SMGL staff in Calabar and select groups of community-based actors. Initially, the staff met in two groups to tell and select the story that best represented the MSC to which SMGL had contributed. The two groups shared their respective MSC stories and selected the one that all agreed best illustrated the MSC brought about under the project. The team also developed an MSC question to use with a small sample of community groups. This was carried out with a couple of women's groups. The questions about the MSC brought about by the project also were incorporated into the KII and group interview guides.

Coding and content analysis were conducted for the qualitative data from interviews and the MSC exercises. This involved coding of key categories, entry of the information into a matrix organized by evaluation question and stakeholder, and comparison of similarities and differences across stakeholder groups by topics relevant to evaluation questions. In the write-up of the findings, the results of this analysis have been triangulated with the results of the descriptive quantitative analysis of the monitoring data and baseline-endline comparison of the Health Facility Assessment Survey.

[4] A list of the BEmONC and CEmONC visited and their locations can be found in Annex IV: Sources of Information.

Quantitative data collection and analysis

Data were abstracted from reports for select key outcome variables related to access, utilization, knowledge, and practice of maternal and neonatal health (MNH). This evaluation also involved review of survey reports and secondary analysis of existing national surveys with a specific focus on CRS.

The evaluation team visited a total of 20 out of 108 facilities, of which there were 11 BEmONC facilities, four public CEmONC facilities, three private CEmONC, and two faith-based organization CEmONC facilities. The 20 facilities were purposively sampled with security-prone facilities excluded from consideration. A facility clinical checklist was developed and administered in these facilities to facilitate clinical reviews. An HF monitoring and evaluation (M&E) checklist was also developed to assess data collection, reporting, use, data quality, supportive supervision, and stockouts.

Figure 1. Map of Visited Facilities

Team members reviewed an opportunistic sample of partographs at each facility visited and reviewed a sample of individual records, registers, monthly summary forms (MSFs), and referral forms. The registers and MSFs were reviewed for accuracy, consistency, and completeness for the months of February, March, and April 2019. There was data abstraction to compare what was in the facility with what was reported in the database.

The quantitative component of this evaluation involved the analysis of routine or programmatic data obtained from Pathfinder. The data were analyzed using MS Excel to generate total numbers, percentages, and graphs. Also, some indicators, such as direct obstetric case fatality and neonatal mortality rates, were calculated by dividing their respective numbers by total number of deliveries in that quarter multiplied by 100. Trend analysis was performed from 2016 to 2019 to understand patterns in increase or decrease of the selected indicators. Quarter 3 in 2016, quarter 2 in 2017, quarter 2 in 2018, and quarter 2 in 2019 were used for the trend analysis to compare each year at the same point in the year, as 2019 is not a complete year.

Secondary analysis of the survey datasets was undertaken with Stata 15.0 SE. The survey datasets used were the 2013 NDHS and Nigeria Multiple Indicator Cluster Surveys (MICS), 2016/2017. Since these surveys were of complex design, the analysis involved accounting for the design features, such as stratification, clustering, and weighting to obtain weighted point estimates. The analysis was descriptive, involving percentages and graphs. Additionally, there was data abstraction from the preliminary report of the 2018 NDHS.

The information obtained through these various methods was reviewed by the team and cleaned before analysis. There was triangulation of data from various sources examining the similarities and differences.

ETHICAL CONSIDERATIONS

Informed Consent: For all group and KIIs, an informed consent statement was read to all interviewees prior to their participation in interviews and their oral consent was requested and confirmed. The statement made clear that they had the option to not participate. The informed consent paragraph was printed on all interview guides.

Participant Confidentiality: Evaluation team members informed all stakeholders interviewed about the purpose of the evaluation as well as their right to confidentiality. No one was compelled to participate in the evaluation, nor would they be subject to any consequences if they refused to participate. Names of participants in group interviews will not be revealed to anyone outside of the evaluation team.

The evaluation team will take meticulous care to protect the identity of individuals interviewed for the evaluation. Except for public officials and project staff, who we will request permission to quote when needed, no other individuals will be identified by name or specific position in a way that would allow them to be identified. All write-ups of interviews will be available exclusively to members of the evaluation team during the period of the evaluation in a secure online folder.

In the process of reviewing a sample of medical records, the evaluation team did not record names or copy individual records from HFs. The aggregated information viewed will be used solely for the purpose of assessing the quality of the record-keeping at the facility level and not to collect information on individual patients.

LIMITATIONS

The timing of data collection permitted visits to about 18.5 percent of HFs covered by SMGL. Security considerations precluded the team from visiting areas where there were inter- and intra-community conflicts or other factors that would have put the evaluation team in possible danger. Facilities in these areas were not visited, although the team did ensure that all three senatorial districts were included in the sample of facilities visited. The facilities selected included both rural and urban facilities, and a selection of communities with easier and more challenging physical access to HFs. There was a delay in the timing of the evaluation, which meant that many key SMGL staff had limited availability for interviews due to other program engagements, end-of-project activities, or previously scheduled vacations. Also, some newly appointed government officials were not fully knowledgeable about the project due to changes in government after the recent elections. The time limitations precluded the evaluation team from speaking to all stakeholder groups. The project-level data on gender issues was not on par with information on other dimensions of the project, and therefore information on changes in gender roles, relationships, and decision-making was limited to the information collected through group and individual interviews. The evaluation team did not have the opportunity to make comparisons between SMGL and non-SMGL facilities in response to the evaluation questions, or to compare performance of key indicators. Also, it was difficult to include more remote HFs. Last, the complete report and dataset of 2018 NDHS were not available to provide some useful comparisons of endline information for the SMGL project with more general trends in the country during the implementation period. The numbers and calculations of comparisons between baseline and endline were not comparable to the analyses conducted by the evaluation team using monitoring data. The three reports represent three different reference periods, with different baseline and endline dates. Unlike the NDHS, neither the HFA nor the evaluation was based on a population-based study.

IV. FINDINGS

EVALUATION QUESTION 1. TO WHAT EXTENT HAS ACCESS TO AND UTILIZATION OF EVIDENCE-BASED, HIGH QUALITY RMNCH INTERVENTIONS CHANGED IN SMGL-SUPPORTED AREAS IN CRS?

In response to Question 1, this section analyzes critical changes in demand as they relate to access and utilization of MNH services. The findings reveal the extent to which key access barriers that result in delays in seeking care (delay 1) and arriving at HFs offering evidence-based obstetric and neonatal care (delay 2) have been reduced. The project aimed to ensure that every pregnant woman has access to a functional HF, attended by a skilled birth attendant (SBA), with access to EmONC as needed. The SMGL project in CRS was designed to contribute to the reduction in maternal and newborn mortality in 108 HFs selected by Pathfinder International. The activities carried out by the project to increase access and utilization of the HFs were evidence-based reproductive, maternal, and neonatal health (RMNH) interventions and were designed to address the "3-Ds."

Access

An initial study (2016) of the location and functionality of women's access to HFs in CRS prior to initiating project activities revealed that there was no functional BEmONC and only one fully functional CEmONC facility in the entire state (SMGL 2016).[5] Access to healthcare for pregnant women was constrained by many factors, including: lack of knowledge and awareness of the advantages of skilled pregnancy-, labor and delivery-, and postpartum care (PPC); cost; religious beliefs; influence of spouses and mothers-in-law; cultural beliefs; preferences for care by TBAs and religious leaders (RLs); distance to the nearest HF and lack of available and affordable transport; and poor quality of care and treatment by healthcare providers. SMGL implemented a number of community-based approaches to influence social and behavioral changes and to address physical and operational barriers that appear to have increased access to healthcare facilities as indicated by the findings of the endline Health Facility Assessment (2019). The various initiatives that appear to have facilitated increased access to HFs are discussed below.

Outreach activities

Community outreach activities served as the entry point for educating women and the larger community on the importance of visiting HFs for RMNCH needs. Three CBOs (one per senatorial district) were primarily assigned to work in all the communities within the radius of the 108 intervention facilities and conduct grassroots mobilization to educate the populace on the importance of using the HFs for antenatal care (ANC), labor and delivery, and PPC, and FP. Their coverage was enhanced by the deployment of medical volunteers recruited by the CBOs and trained by SMGL to do home visits, make facility referrals, and organize community outreach. The CBOs also worked with community actors, such as WDCs and community leaders, in educating the communities and sometimes used health campaigns and free medical tests as a way of attracting people to meetings. While the primary focus was to generate demand by women for RMNCH services, they also educated other stakeholders, including

[5] In other words, there were no facilities that met the World Health Organization (WHO) criteria for BEmONC with the capability of performing seven signal functions: parenteral treatment of infection (antibiotics); parenteral treatment of severe pre-eclampsia/eclampsia (e.g., MgSO4); treatment of postpartum hemorrhage (e.g., uterotonics); manual removal of retained products of conception; assisted vaginal delivery (e.g., vacuum-assisted delivery); manual removal of placenta; and newborn resuscitation). There was only one facility that met the criteria for CEmONC, with the capability of performing signal functions that include: surgical capability, including anesthesia (e.g., cesarean section); and blood transfusion.

spouses, mothers-in-law, and RLs about "danger signs" and to encourage and support women to use HFs. For instance, women who delivered at the PHC Center, PHC Emangabe, within the year preceding the study stated that GHF (one of the CBOs) sponsored sensitization activities in the form of town hall meetings. They also conducted periodic outreach to and facilitated discussions with pregnant women's spouses. However, despite the strong presence of the CBOs in some communities, in other locations visited by the evaluation team, both community-based actors and facility staff were not aware of CBO presence in their areas.

Findings also confirm that other actors, such as Community Health Extension Workers (CHEWs), WDCs, and TBAs, were simultaneously involved in community outreach and home visits that stakeholders said contributed to increased access to HFs. The qualitative observations from the study showed high presence of CHEWs across all facilities visited, accounting for increased engagement with women at the community level through home visits and community outreach for facility referrals forming an essential part of the CHEWs's role. Similarly, some WDCs and TBAs also attested to community education and referrals to HFs. For instance, the group interview with WDC members in Idomi, Yakur LGA showed that the WDCs in the community carry out sensitization meetings in the communities, markets, and churches, and monitor TBAs who are thought to be delivering at home. Some key messages used during sensitization are: "*The risk of dying is greatly reduced when a baby is delivered at the PHC," "The risk of HIV transmission is also reduced when delivery is done at the PHC," "Women who deliver at the PHC get mama kits*," and *"Women are given FP services immediately for free after delivery to assist women in spacing their children so they can have time for economic activities*." In Ikot Nakanda, a woman participant in the WDC group interview stated:

> *"Anywhere any member of the WDC recognizes a pregnant woman, such woman is immediately educated and encouraged to go to the healthcare facility for ANC and ensure she delivers at the facility . . . we also engage spouse of such a pregnant woman to sensitize him to take his wife to the healthcare facility for ANC and delivery."*

Community outreach, home visits, and follow-ups were all stated as contributing to increasing access to HFs.

The HelloMAMA project, a component of the SMGL, worked through mobile phone messages to convey important information for pregnant women registered on the platform. The nurses at the facility were trained and assigned a code for registering women once they signed up for ANC. The program then sent messages to them throughout the pregnancy period through delivery, and until the child turned one year. HelloMAMA used a text-based and voice messaging service to raise awareness and to educate pregnant women on how to prepare for delivery, particularly those who have previously undergone C-sections, FP, and circumcision. The partners were also receiving messages on how to be more supportive.[6]

The series of text messages were cited by health workers and women who had delivered in the last year as contributing to educating women about the different phases of their pregnancy and childcare, which

[6] HelloMAMA provided services to a total of 47 Maternal Child Survival Program—and SMGL-supported HFs in Ebonyi and CRS, respectively. Some 47,276 women and an additional 26,752 gatekeepers (e.g., husbands and mothers-in-law) were given access to the system. Women could choose whether they wanted to receive text or voice messages in multiple languages, so they did not need to have a smart phone. Additionally, the HelloMAMA report stated that digital penetration in Nigeria is quite high, but more limited in rural areas (Pathfinder, March 2019).

also generated uptake of facility-based services, particularly as the women also shared their experiences with other women in the community. For instance, one of the staff members interviewed at the General Hospital Ogoja stated that the program was very interesting and provided a means for women to come to the facility to ask questions based on the messages they received. Another facility head in the study stated:

> *"Also, the education they get from the facility . . . is helping them, especially when HelloMAMA was still in place. We registered so many of them . . . [as a result of the] HelloMAMA messages that were coming to them . . . and they were even asking whether we are doing magic or those people sending those messages are witches to be sending those types of messages. All of them are impressed, as they go back, they tell their friends and that is how they keep coming. Even at midnight, you see them coming, at any time. We do not deny people the opportunity to register, we must do what we are supposed to do for the person."* (CHEW interview)

Many women interviewed stated that the messages were almost like magic as they seemed to anticipate the questions they had at the precise moment when they were experiencing different stages of their pregnancy. They were amazed that the program was so personally attuned to their needs.

While the HelloMAMA project was cited as effective for educating the women and their partners on good practices, birth preparedness, danger signs, and other useful information imperative for comprehensive maternal care, the project was only implemented across some intervention facilities. As a way of sustaining the scheme, the project was handed over to the CRS government toward the end of 2018, but at the time of the evaluation, the program was not functioning in CRS. This is leaving women who are currently pregnant without the benefit of the program. It is not clear what is causing the delay in implementation by the CRS MOH.

Role of the TBAs

SMGL also engaged TBAs in intervention communities to identify pregnant women and provide them with escorts to the facility for ANC registration and delivery. The program provided incentives to the TBAs for referring women for delivery by providing Naira 3,000 per woman escorted to the facility during labor. The argument for an incentive-based approach for TBAs was premised on an economic justification that most TBAs conducted deliveries as an economic activity and changing that role should be financially viable for them, as well as in the interest of getting women to deliver at healthcare facilities. Findings indicated that the TBAs also were involved in home visits and follow-up, and sometimes joined the WDCs in organizing community outreach. For example, some TBAs interviewed at the Comprehensive Health Center, Ikom disclosed that they have been partnering with WDCs to organize community outreach to religious institutions. Similarly, the TBAs interviewed at PHC Center Indundu attested to sensitizing women in the community on the need to register at the HF and sometimes engaged spouses of the women when they sensed a delay by the women in seeking care. Some of the TBAs also attested to assisting in nonclinical procedures and accompanying women during delivery at the facility.

Incentives by SMGL started in 2018. The project appeared to be less successful in convincing RLs and religious-based birth attendants to refer women to HFs, although there were some notable exceptions—i.e., pastors who became advocates for HF deliveries. There was a spike in the institutional deliveries in 2018 but also an increased reporting of maternal deaths, which may have been attributable either to better reporting or the continued practice of church-based deliveries.

While incentives seem to have worked in the short run to encourage TBAs to refer clients to the HFs for ANC and delivery, it was not possible to assess how permanent the effect would be. TBAs interviewed by the evaluators stated that with or without the incentives they now understand the importance of women receiving skilled care at HFs.

However, the incentives could have potentially adverse outcomes in terms of sustainability and, once suspended, could stimulate the previous behaviors (home/church births). To counter this effect, some WDCs have come out with plans to support TBAs with incentives and continue the escort program. Others have imposed local ordinances that penalize and fine TBAs caught delivering babies in their homes.[7]

Birth preparedness, perception of improved care, and recognition of danger signs

SMGL invested in building the capacity of healthcare workers and other outreach-related individuals and groups (e.g., CBOs, community volunteers, WDCs, TBAs, and ETS) on danger signs to increase prompt referrals to HFs as the need arises. Health workers were also trained to teach women about birth preparedness and the recognition of danger signs during ANC visits. Health workers and volunteers encouraged women and their partners to set aside money and identify how they would get to the healthcare facility during pregnancy so they would be prepared for any emergency should it occur. Many stakeholders stated that this sensitization during ANC contributed to the surge in use of HFs. Group interviews with women who delivered at the HFs, as well as health workers within the facilities, also pointed to the crucial role women's perceptions about improved care within the facility played in generating demand for and utilization of ANC, FP, and skilled delivery care. Women's positive experiences in the HFs were also responsible for increased utilization of services, as many of them went back to their neighborhoods to inform others about improvement in healthcare and treatment by the health workers. For example, the facility head of PHC Ekumtak recounted such an experience:

> *"It is because the staff are working and are always here. There is always someone on duty. And the way we behave with them, our relationship with client also matters. I can remember one day a client came to do a scan because we are doing scan also. She came from another community. When she came we were having antenatal that day so she sat down and listened to the health talk we delivered. She was impressed and she decided to register with us. Unlike where she registered before where she could not access such health talk, she was pleased with our facility. That is why they are coming."*

Moreover, as will be clear in the discussion of Evaluation Question 2 of the report, the investment in capacity training of health workers greatly increased their knowledge on best practices for delivery and postnatal care, raised consciousness on the consistent use of partographs, and enhanced their understanding of when to refer to a CEmONC facility, based on interviews with both CHEWs, doctors,

[7] While the effects of these policies have not been studied, they run counter to a rights-based approach to RMNCH, and rather than empowering women to make an informed choice about their healthcare, they legally constrain women's rights. Nevertheless, as far as the evaluators know, Pathfinder was not involved in developing or supporting local statutes that fined TBAs for delivering babies in their homes. It was also not clear whether these statutes also applied to churches and if they were subject to the same fines for delivering babies within religious establishments. Pathfinder was aware of these local laws as the WDCs spoke very proudly about them. The evaluation team was not aware of any interventions on the part of Pathfinder to discourage WDCs from passing these statutes. There is also not evidence to-date that these statutes have been enforced, or that they will be. It was the understanding of the evaluation team that they were more of a public statement on the importance of delivery by a skilled healthcare provider in an HF than an actionable policy. In the conclusions and recommendations section, the evaluators recommend monitoring how the policies are implemented to ensure that women's rights are respected.

and nurses, as well as their instructors and supervisors. The training also increased their confidence and job satisfaction, which translated into more respectful care and friendlier attitudes toward their clients. For instance, a CHEW in PHC Emangabe stated:

> *"Before, if I deliver a baby and the baby comes with difficulty in breathing, we normally beat the babies back but now with the training and ambu bags to restore the baby's breath not with the beating method of before and how to know if the labor is prolonging; if it is improving or not improving and when to refer a pregnant woman on labor."*

These changes contributed to a women's perceptions of better treatment and improved care.

Cost reductions

The program also sought to reduce economic barriers by cutting the cost of services. Women accessing RMNCH services across CRS encounter varying costs, even where cost subsidies have been applied, depending on ownership of facility (faith-based, private, or public). The evaluators found a lot of variability in cost, even across public facilities at the same level, ranging from free to about Naira 8000 for a delivery at a PHC. Though findings showed nuances in the associated costs for different components of maternal healthcare services, such as ANC registration and normal delivery across PHC facilities, the program had reduced a significant cost component for community women, particularly with the free donation of Mama Kits to all women who deliver in any public- or faith-based facility and the introduction of the ETS drivers who transport, free of charge, women having maternity-related emergencies. For instance, in an interview session with women who delivered recently in the facility at PHC Ekumtak, the participants stated that most women who deliver at the PHC pay little money and some who cannot afford to pay due to poverty sometimes receive the services at no charge. This reduction in the cost element was also identified as contributing to the increase in healthcare access and utilization.

The Mama Kits were cited by both community stakeholders and healthcare workers as a major draw for HF deliveries, as they alleviated out-of-pocket expenses for basic delivery supplies. This is another incentive that may not be sustainable, although there is some indication that the CRS PHCDA will continue to provide Mama Kits.

ETS

SMGL implemented a community-based transportation model, known as *ETS*, to assist in transporting women having pregnancy-related emergencies to the BEmONC or CEmONC centers. This entirely free service is funded and maintained by the WDCs who recruit motorcycle owners within each community and pay them a token fee (below the actual price) when their services are used. SMGL trained them and provided them with kits (jackets and helmets) for identification, while their mobile numbers are posted on the walls of the facility and circulated among women who attend ANC. In reality, the service is available to any woman in labor and not restricted to those experiencing emergencies. The SMGL ETS initiative was complemented by the donation of a tricycle ambulance by the state government, which came without a driver or fuel, so is only functional in areas where the WDC or a donor has financed its use.

Evidence from the qualitative interviews confirms the contributory role of the program in raising demands for facility access and uptake. For instance, one of the women who delivered within a year of the evaluation at the PHC Ugep, shared her story during a group interview using MSC about how she called one of the ETS drivers to take her to the PHC when her labor started. At the facility, the staff

realized she had an obstructed labor and immediately referred her to the general hospital. The same ETS driver who took her from her home conveyed her to the general hospital where she received a C-section.

Though the program adopted a community-based approach to the maintenance and financial replenishment of the ETS scheme by training WDCs on "SMART" advocacy to raise funding for such a scheme, there are concerns, based on feedback from different communities during the evaluation, that the community-based approach is not fully integrated and accepted across all communities, which raises question about the sustainability of the scheme.

Linkages between public/private facilities

SMGL engaged 108 facilities, including public PHCs (BEmONC), public secondary facilities (CEmONC), private CEmONC, and faith-based CEmONC throughout the project implementation phase by providing training support, equipment supply, and facility renovation. The level of engagement, however, varied across the facility as there was more focus on public facilities. The engagement was geared toward strengthening linkages between healthcare actors, particularly in terms of referrals from BEmONC to CEmONC. Findings from the study showed that increased referrals between public and private facilities also contributed to women getting timely and quality care at the appropriate level relative to their needs. The heads of public and private facilities who participated in SMGL stated that meeting each other at training sessions and other project-sponsored events permitted them to forge personal relationships that facilitated collaboration across facilities and, in turn, contributed to reductions in facility-based mortality. Similarly, although not part of the TBA referral scheme, some private CEmONC facilities received referrals from TBAs. The head of a private hospital stated:

> *"Like now, because of Pathfinder, they are referring pregnant women to come and register. Some of them come with referral notes because they have people that go down to the village and fish those people out to come and register. Also, like this year, we have received two labor cases from a traditional birth attendant. The pregnant woman and the traditional birth attendant came to the hospital and that was the instruction from Pathfinder. When such a thing happens, we take note of them, they will pay the traditional birth attendant."*

The monthly cluster meetings at the LGA level were also identified as deepening the ties among healthcare actors in the state as they provide opportunities for these actors to learn from one another through experience-sharing and adopting best practices toward a central goal of reducing maternal and neonatal mortality in the state. Many of the HF staff members interviewed stated that the meetings facilitate collaboration and improve referrals. For instance, one of the healthcare workers in a CEmONC HF in Ikom stated that some private facilities come to them to get some vaccines when they run short.

The stakeholders agreed that the monthly cluster meetings had contributed to health learning and relationship-building. Some of the LGAs are planning to merge the cluster meetings with the local government meetings to continue the initiative; however, they may require some administrative help from SMGL in ensuring a proper integration of such meetings.

Infrastructure renovation

The program also invested in renovation of some facilities to change the look of health centers and improve the quality of care. Examples of renovation work recorded during the qualitative observations included changing ceilings and windows fittings, painting and tiling walls and floors, placing partitioning,

constructing boreholes, etc. Electricity was also a major challenge across most of the facilities and SMGL installed solar lamps, particularly in the labor room of all the facilities, which was noted as contributing to improved quality of care by extending the hours for attending deliveries. The renovation and beautification was also cited as generating demands for facility access and utilization. For instance, one of the staff at the general hospital, Ogoja, remarked:

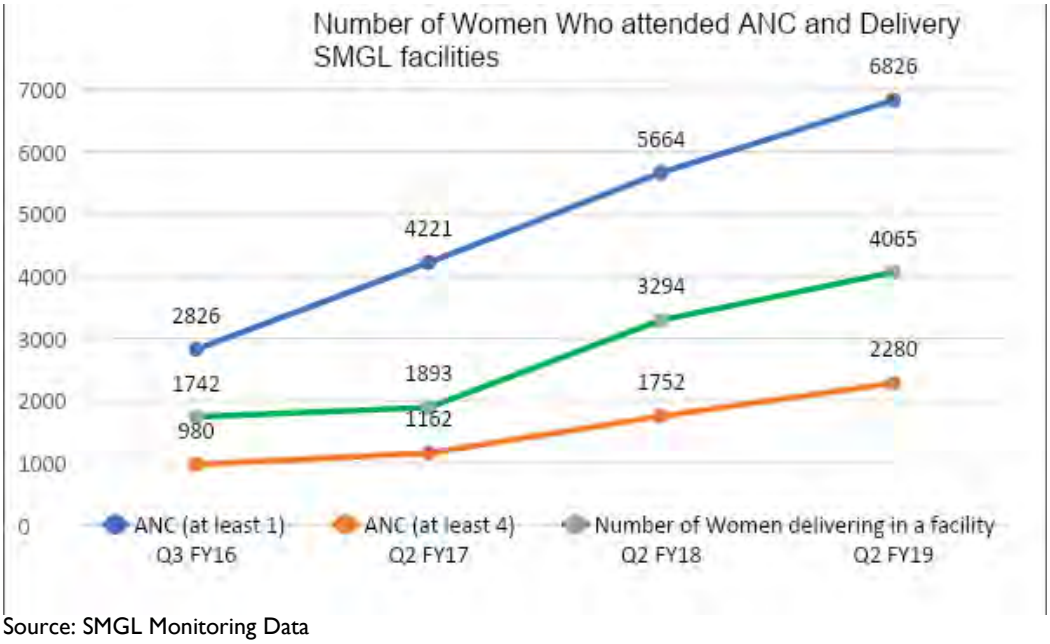
"When they come, they will say haaaa, this place is beautiful ooooh. I must come deliver here."

The criteria for selecting facilities for renovation was not clear. The evaluation team saw some facilities that had been fully renovated but had little demand for services, delivering merely five babies per month. There were other facilities with high demand and only minimal renovation. Almost all PHCs lacked running water in the delivery room or for showers and toilets. Of the PHCs visited by the evaluation team, only two received assistance from Pathfinder with bringing in running water, and in both cases, water was not available in the delivery rooms 24 hours a day. Most PHCs also lacked a constant source of electricity powerful enough to run a refrigerator. They maintained a cold chain for oxytocin with ice in a cooler. The project provided a solar panel sufficient to provide a light in the delivery room and a warming lamp to keep a baby warm immediately after birth during its physical exam.

Utilization

ANC and Institutional Deliveries: SMGL appears to have greatly increased the number of ANC visits. There is still a large disparity between the number of women who have one and those who have four ANC visits (WHO standard). According to the project monitoring data, there is also a widening gap between women with one ANC visit and delivery at the HF, despite the increased trend during SMGL implementation. The SMGL data indicate that only 56 percent of the deliveries occurring in the HFs have at least one ANC, and approximately 30 percent of women had at least four or more ANC visits during their pregnancy. SMGL monitoring data also reveal that they have not appreciably closed the gap between the number of women who come in for ANC prior to 20 weeks of pregnancy compared to those who come in at 20 weeks or later.

Figure 2. Trends in ANC Visits and Institutional Deliveries



Source: SMGL Monitoring Data

A comparison of data from the Health Facility Assessment baseline and endline reports shows a similar trend (Table 4). Both the number of women with four ANC visits and the number of women delivering in an HF have increased by two-fold. Both have superseded the indicator targets. One of the limitations of the evaluation was not having the opportunity to interview women who had attended ANC once and decided not to deliver at a HF to understand what factors continue to influence their decisions about seeking and capacity to reach care. Women who had delivered in the last year said that a combination of incentives (e.g., soap received at each ANC visit, and a Mama Kit at delivery) along with getting to know the healthcare providers during ANC visits encouraged them to deliver in the facility, even if they had not done so with their older children.

Table 4. Change in Facility Attendance for MNH Services

Indicator	Baseline[1]	Endline[2]	% change
Total number of women attending antenatal at the facility	66,963	74,911	12%
Number of women who had 4th ANC visit	6,117	8,988	47%
Number of women attending PNC	3,149	7,298	132%
Number of women delivering in a facility	13,472	17,727	32%

Source: Pathfinder 2019. [1]Jan–Dec 2015, (68 Facilities), Jan–Dec 2016, (30 Facilities); [2]April 2018–March 2019 (98 facilities)

EVALUATION QUESTION 2. HOW HAVE PROJECT IMPLEMENTATION AND ITS MODE OF DELIVERY CHANGED QUALITY OF SERVICE DELIVERY OF MATERNAL AND NEWBORN HEALTH INTERVENTIONS AND COMPREHENSIVE FP SERVICES?

This section of the report provides an overview of changes in the quality of services during the implementation of SMGL. It describes and assesses the tripartite model of quality improvement that includes capacity building on evidence-based practices, supportive supervision, and mentoring. In the last six months of the initiative, SMGL introduced an accountability procedure based on the Nigerian national health policy for Maternal Perinatal Death Surveillance Response (MPDSR) for quality improvement. It has become a routine part of cluster meetings and is overseen by the federal teaching hospital. Although SMGL also supported facility upgrading and solar energy for lighting in the delivery room, the four interventions described above were the most critical factors contributing to improvements in the quality of services.

Capacity building

SMGL contributed to strengthening the capacity of health workers through multiple rounds of trainings and refresher trainings delivered in collaboration with the CRS MOH and the CRS PHCDA. Prior to the health providers' training, master trainers were selected from the CRS MOH, CRS PHCDA, federal teaching hospital in Calabar, and professional societies, to create a critical pool of mentors and cascade the training to HF staff. This allowed for the creation of a diverse group of facilitators focused on building the capacities of the health workers operating at different levels of care.

SMGL trainings included lessons (or modules) in FP, mainly LARC, postpartum family planning (PPFP) and post-abortion care; EmONC; essential newborn care (ENC), and MPDSR. Some providers were also trained on M&E and data collection, gender, and youth-friendly spaces.

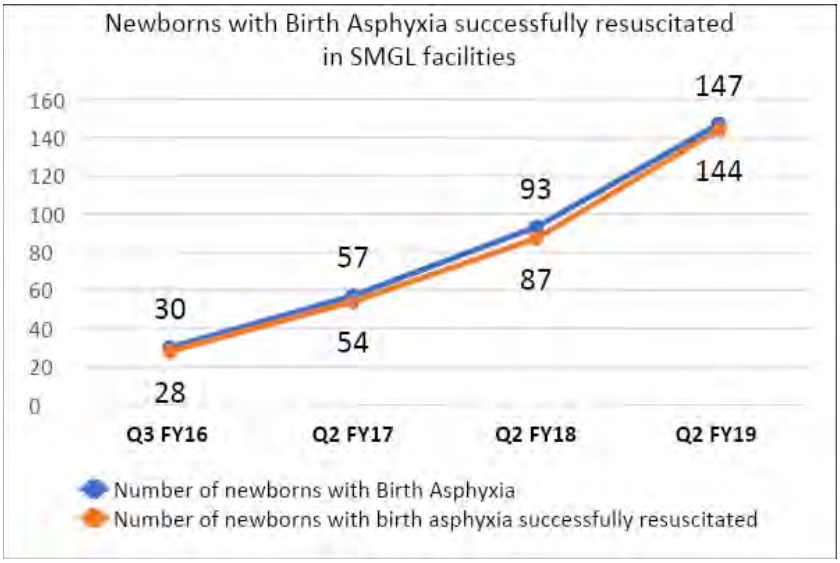
Health workers selected for off-site training had to commit to "cascade" the training to the HF staff who did not participate. The training emphasized key messages and skills, with a major focus on the right time for referrals.

The facilitators used a variety of tools, including manikins and medical equipment to simulate real-life emergencies. SMGL offered trainings by categories of health professionals (doctors, nurses/midwives) using the FMOH training curriculum and revised and adapted the modules to a lower background (such as CHEWs), simplifying both the language and the clinical skills training. Consultants from medical associations were involved as trainers. The FMOH gave its approval concerning the training material used by the SMGL project.

During the data collection in the HFs, the evaluation team learned that the ENC, and particularly the newborn resuscitation technique, has made a major contribution to the survival of babies with breathing problems at birth. Before the SMGL training, a majority of PHC healthcare providers slapped babies born without any sign of spontaneous breathing on the back. If they did not respond, they assumed them to be stillborn, and simply left them on the table to die.

Today, the health providers have learned about the window of opportunity given by the "first minutes of life" and start resuscitation maneuvers immediately for 95 percent of newborns with breathing difficulties. The number of *averted newborn deaths*—newborns who, without the training on neonatal resuscitation and the equipment provided by SMGL, would not be alive today—is one of the long-term results of the training.

Figure 3. Number of Newborns with Birth Asphyxia Successfully Resuscitated



Source: SMGL Monitoring Data[8]

[8] Due to the incompleteness of FY 2016 and FY 2019 data, for comparison, only data collected during quarters 2 and 3 were presented.

Based on the comparison of SMGL figures from the Health Facility Assessment baseline and endline studies, newborn resuscitation with bag and mask demonstrated the MSC (see Table 5).

Table 5. Prevalence of Newborns Resuscitated

	Baseline 2016	Endline 2019	Significance of change
Newborn resuscitation with bag and mask	39%	84%	⬆

Source: SMGL Endline Health Facility Assessment, 2019

Although 95 percent of the interviews carried out with the health providers showed a high degree of satisfaction with the trainings received, interviews with dignitaries from the CRS MOH reported that few trainings were planned without prior consultation with the CRS MOH. Having selected CRS MOH staff in pre-retirement without informing the CRS MOH, Pathfinder has caused temporary staffing shortages, because the personnel were removed from their duties without consent or knowledge of the supervisors for trainings. This was particularly problematic when training workshops were long or out of town. CRS MOH representatives also reported limited involvement in the design of the trainings, consultation on costs, selection of the participants, and execution.

MPDSR

As part of the training provided, SMGL has supported the MOH policy in maternal and perinatal death reporting. The health providers have received training concerning the data collection and transmission and quarterly meeting were organized by SMGL to, among other reasons, share causes and numbers of maternal deaths. The systematic review of the mortality data helped improve the quality of care and accountability. As for the chain of communication, the data on deaths are transmitted to Calabar teaching hospital for further investigation. The establishment of the MPDSR committees and the deep involvement of Society of Gynecology and Obstetrics of Nigeria (SOGON) obstetricians are the bases for the continuity of this activity. Seventy-five percent of the medical associations have collaborated with SMGL and have described how the project has supported them in the implementation of the MPDSR policy.

The policy institutes a "*No blame, no shame*" attitude: the health providers are not punished but the cluster members support a proactive remedial approach. During the quarterly meetings, which bring together all the healthcare levels (community, LGA, private and public HFs, teaching hospital doctors, and state representatives), the maternal and perinatal deaths are reviewed and analyzed, and discussions are held to avoid similar outcomes in the future.

National guidelines on MPDSR are available for the primary- and secondary-level HFs and the MOH will release guidelines for the private HFs and community-level shortly. MPDSR was not an SMGL policy initiative but they contributed in large measure to its adaptation and implementation in the local context. Nevertheless, it is still a work in progress. About 50 percent of the interviews held with MPDSR MOH officers informed the evaluators that not all the HFs or communities are reporting on maternal deaths: this attitude of concealing data is still present in some facilities and additional sensitization and awareness of the benefits of transparency to address mistakes is needed.

Figure 4. MPD Surveillance and Response Cycle

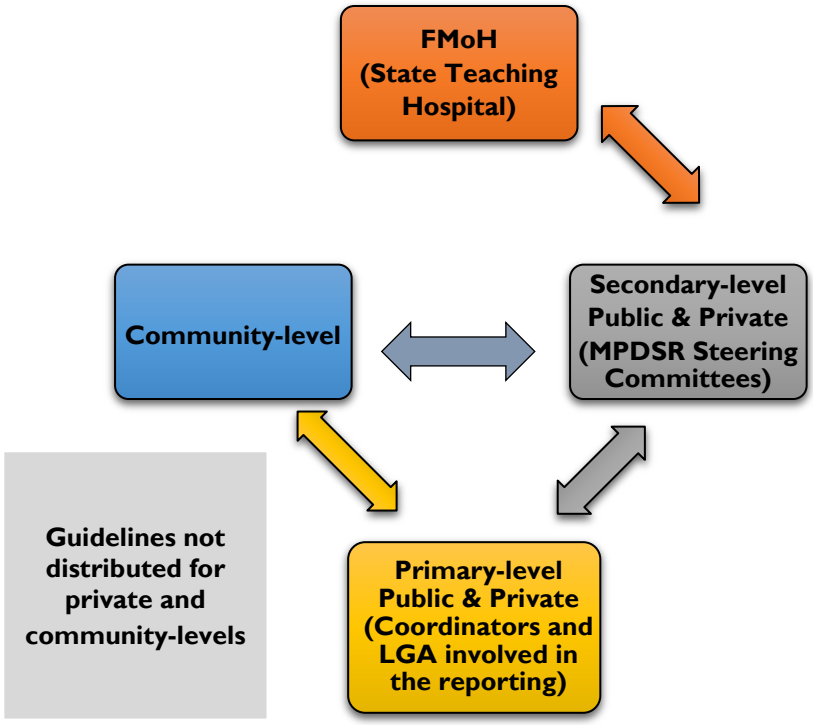


Table 6 shows the prevalence of maternal intra-facility fatality cases and pre-discharge deaths in SMGL facilities (baseline vs. endline).

Table 6. Maternal and Pre-Discharge Deaths

	Baseline 2016	Endline 2019	Significance of change
Maternal deaths*	35	16	-54.2

* Source: Pathfinder, 2019. Facility-based maternal deaths by the following causes: Postpartum hemorrhage, sepsis, obstructed labor, eclampsia, unsafe abortion complications, HIV/AIDS, TB, and malaria.

Respectful Care

As described during the interviews with HF providers, SMGL has increased the provision of quality of care of RMNH services. SMGL was able to build knowledge and conscientiousness among the health providers and significantly change their attitudes toward patients.

Interviews with HF staff affirmed that trainings have improved health workers' attitudes, approaches, and ways of interacting with patients, and they have learned about respectful care. SMGL training has helped them have a friendlier attitude toward patients, and women particularly, while attending them.

> *"Each woman is entitled to be treated as an individual."* (General hospital staff, Ugep)

> *"This training has changed the attitude of caregivers. This training we have done has changed the passion; health workers now have passion in what they are doing."* (Catholic Maternity Hospital staff, Ogoja)

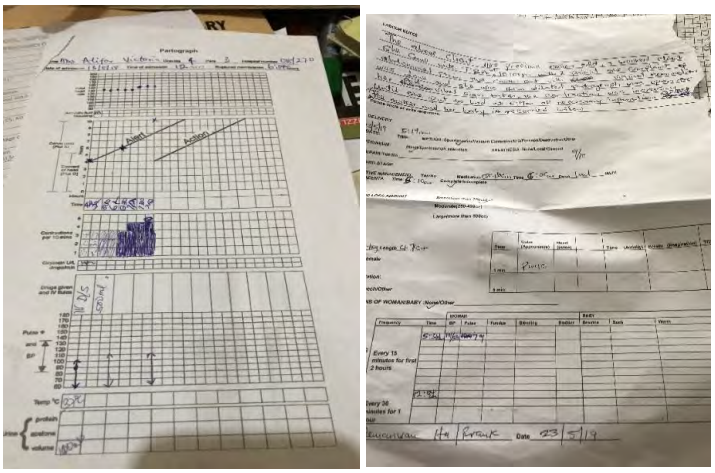
Community members confirmed the changes in attitude on the part of health workers. A partner of a women who delivered in the PHC Indundu said:

> *"Immediately when my wife started her labor, I rushed her to the hospital (PHC). When we arrived, there were two nurses standing outside. They both rushed to assist me and held my wife and gently guided her inside the hospital. . . . I heard them at intervals encouraging her and petting her saying that everything will be fine. I was happy and confident that she is in safe hands . . . the nurses in the past are not like that, they will shout on her and even abuse her."*

Use of Partograph

SMGL supported the monitoring of the deliveries using the partograph and started the collection of this indicator in FY 2017. It was not included prior to this period because it was not part of the original list of SMGL project indicators and was also not a USAID-approved indicator (therefore not in the approved Monitoring, Evaluation, and Learning [ME&L] plan).[9] Partographs were theoretically acknowledged in the CRS HFs but their utilization prior to SMGL was limited (see Figure 5). Seventy percent of the interviews with the health providers in the HFs described how the use of the partograph has become standard procedure for each labor since the presence of SMGL.

Placing mentor midwives in PHCs for on-job mentoring has strengthened the confidence of the health providers in the use of partographs. During HF supervision visits, Pathfinder staff have monitored the completion of the partograph and have sustained its use and practice. HF staff reported that this tool has increased the early detection of obstetric complications and has allowed appropriate interventions (i.e., C-section) and prompt referrals.



Samples of partographs

"Pathfinder also affected the practices in the hospitals, like use of partographs. A lot of innovation came into the health sector through Pathfinder." (Melrose Hospital staff, Ikom)

Fifteen percent of the partographs sampled during the evaluation indicated they were used for only a limited amount of time before the delivery (1 hour to 30 minutes). HF staff explained that some pregnant women still remain with the TBAs during the majority of the labor and arrived at the HF just before the

[9] It is in the 2018 revised project MEL plan.

expulsion phase. This practice seems to answer why some of the partographs were completed only for the active management of the third stage of labor (AMTSL) and for the APGAR score.

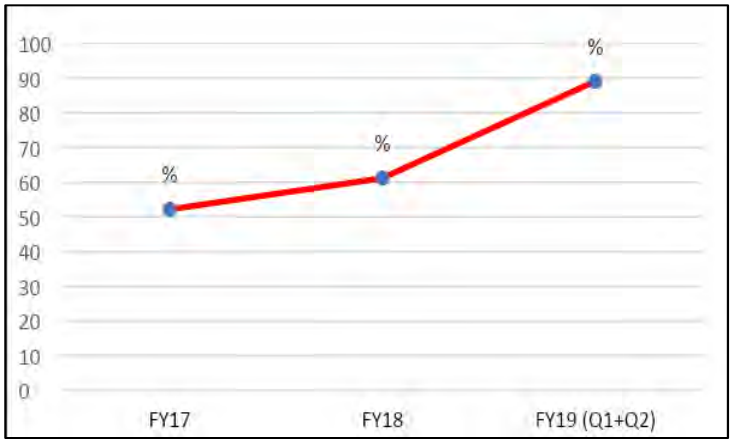
> *"HFs previously did not administer oxytocin to all patients except those who are bleeding or look like they will bleed. Pathfinder has taught us that as soon as a woman delivers her child, she should be given oxytocin."* (HF, Ansor)

Yet, 50 percent of the maternity wards staff reported that the time required to document the status of the pregnant woman in labor, and the workload in high-volume facilities, had an influence on the completion of the partographs. When the congestion in the maternity wards is added to the lack of human resources for health, the partograph's completion rates drop down as this tool is a time-consuming practice.

The training received on how to use the partograph has also changed the attitude of the health workers about acceptable positions for delivery. Women are no longer confined to a single position while delivering as their SBAs allow them to move about freely.

The evaluation team identified multiple gaps in the completion of the partographs. Although 100 percent of the HFs visited during the evaluation showed availability of the tool, the evaluation team noticed that the plotting was not appropriate in at least 50 percent of the surveyed sample. The partograph completion is still a work-in-progress.

Figure 5.Percentage of Deliveries Monitored Using a Partograph



Source: SMGL Monitoring Data

Recent monitoring data has indicated a decline in the use of partographs in some PHCs. SMGL has looked into why this has occurred and concluded that it may be because many of the trained nurses and midwives have left those facilities and their replacements did not know how to use the partograph. The SMGL staff have provided continuing education in those facilities (according to interviews with SMGL staff).

Medical equipment, supplies, and contraceptives

Partnerships of SMGL with Project CURE and WeCareSolar[10] have allowed the distribution of medical equipment and supplies for the project's HFs. This equipment has greatly benefited the health staff in both the early recognition and management of obstetric and neonatal complications.

Examples were given about the provision of solar suitcases and bulbs and how those have made it possible to attend births during the night; ambu bags and mucus extractors have helped newborns

[10] www.wecaresolar.org

breathe and incubators have increased life expectancy in preterm babies. These findings confirmed what is reported in the HFA 2019.

Obstetric and neonatal tray

As mentioned under the Evaluation Question 1, the provision of delivery bags (Mama Kits) has not only increased access and utilization of the HFs but has also improved the quality of care, according to both health workers and HF clients. In fact, most of the items included in the bag are supplies used by the health providers assisting the delivery, which women and their family members would have to purchase if not provided in the Mama Kits.

Table 7 summarizes the results of the rapid survey in the 20 HFs visited during the evaluation. In general, the availability of equipment and drugs for the provision of seven signal functions was appropriate. The storage of a temperature-sensitive drug, such as oxytocin, needs to be improved. In the majority of the facilities surveyed, the uterotonic was stored in ice pack boxes and, in a few instances, oxytocin was found in the cupboard.

Table 7. Equipment and Drugs Necessary to Perform the Seven Signal Functions in SMGL Facilities

1. Women records with attached partograph	70%
a. APGAR score correctly mentioned	65%
2. Availability of oxytocin	100%
a. Storage at 4–6 degrees (ice box mainly)	80%
3. Availability of Ambu bag + masks	100%
4. Availability of magnesium sulfate injection	100%
5. Availability of antibiotics	
a. Ampicillin IV* *Ceftriaxone available in substitution	55%
b. Gentamicin IV	85%
c. Metronidazole IV	50%
6. Availability of vacuum extractor	100%
7. Sterile gloves for manual removal of the placenta	100%

Oxytocin vials stored in cupboard

Concerning FP, it is difficult to predict the intended contribution of FP activities in SMGL facilities due to the presence of other actors. In fact, the existence of several organizations, such as Marie Stopes International and FHI360, have made it difficult to determine SMGL's contribution to contraception uptake.

"If there is [demand for FP], I won't attribute it to Pathfinder because there are many people on it. But generally, there is an increase in awareness in the administration of FP." (Melrose Hospital staff, Ikom)

Indeed, SMGL has robustly contributed to FP skills building with trainings, as previously mentioned, and efforts were made to build the capacity of the CHEWs in LARC—implant insertions and removals. This training adheres to the National Task-Shifting policy, which permits CHEWs to provide certain contraceptive methods (implants and injectables). In addition to LARC, SMGL FP activities also focused on PPFP.

Some of the FP achievements from the endline survey are presented in Table 8.

Table 8. Changes in the Uptake of Contraceptives, 2016–2019[11]

Indicator	Baseline[1]	Endline[2]	Percentage change
Number of women who accepted a short-acting, long-acting or permanent modern method of contraception from facility after giving birth during the postpartum period	727	15,558	2,040%
Couple years' protection Number of units of FP methods provided to PNC clients	4,572	44,324	869%
IUD	348	692	99%
Implant	110	8,358	7,498%
Sterilization	27	20	-26%
Oral contraceptives	186	3,499	1,781%
Condoms (male and female)	199	78,426	39,310%
Injectable	338	1,664	3,92%

SMGL Monitoring Data: [1]Jan–Dec 2015, (68 facilities), Jan–Dec 2016, (30 facilities); [2]April 2018–March 2019 (98 facilities)

Supportive supervision

To ensure the continued availability of capable human resources in health in the state and in supported facilities, the SMGL project provided a combination of supportive supervision and mentorship of the health workforce on RMNCH services at different levels of the health system for ANC, labor and delivery, PPC, and FP. To complement this supportive supervision and mentorship, particularly in comprehensive HFs that have a higher volume of patronage for MNH services in the state, the project supported the deployment of retired midwives as on-the-job mentors for healthcare providers in these EmONC sites, and also provided continued support for improved quality of documentation and service through deployed facility support staff in the EmONC facilities.

Mentorship app for midwives

[11] The first indicator in Table 8 is not an indicator in the project MEL Plan, which has instead an indicator "percent of women who deliver in a facility that received post-partum contraception." The percentage increase for LARCs, IUDs, and implements is most likely attributable to SMGL. The increases in condoms, injectables, and pills are most likely not exclusively attributable to SMGL as there are several projects, including Marie Stopes, FHI360, and other HIV/AIDS programs. As with any facility-based FP data, it is difficult to ascertain who is responsible for what. The FMOH provides most contraceptives.

Supportive supervision by doctors from professional societies, such as SOGON, NISOMN, and AGPMPN, was another contribution of SMGL. Staff from these organizations visited the HFs every two months and they used checklists and direct observation to assess the performance of the health workers. Sometimes the supervisory visits were conducted jointly with MOH representatives.

> *"Before now, some staff feel reluctant to work but now, since they know that visitors are always at the facility, they have to be on duty as expected."* (PHC staff, Ekimtak)

According to both supervisors and supervisees, the supervision activities have increased job ownership and sense of responsibility of the health providers. For example, the staff now remain on-post until another staff resumes his or her duty. The evaluators found evidence of significant behavioral changes among healthcare providers due to the efforts of SMGL that have contributed to improved quality of care and better interpersonal relations with clients. The supportive supervision provided by SMGL was also particularly important to certify the CHEWs in implant insertion.

Supportive supervision has boosted staff capacity as well as increased their confidence to ask questions and engage in continuous learning while on the job. Even lower-level health workers trained by the project committed themselves to training colleagues who had attended the project-led training. The post-training follow-up reinforced the skills they learned in the course by demonstrating the skills in a real-life setting. The supervisory role SMGL modeled and implemented greatly enhanced the capacities of the health providers and improved their interactions with their clients in HFs and during community outreach.

> *"They will not just give you a thing and go and sleep. They follow up to ensure that you do what they expect you to do. . . . They always have a target in whatever they want [you] to carry out."* (Holy Cross Catholic Hospital staff, Ikom in reference to the supervisory process provided by Pathfinder-supported mentor midwives)

Clinical mentoring

To strengthen the capacity of the health providers, SMGL supported and sponsored the deployment of medical doctors (obstetricians and neonatologists) from Calabar Teaching Hospital to the secondary-level hospitals, and the placement of retired midwives toward the primary-level HFs. The goal of those deployments was to observe, correct, and mentor the health providers directly during their duties.

A partnership with three medical associations was formed: SOGON, Nigerian Society of Neonatal Medicine (NISONM), and AGPMPN. The last supported volunteers with SMGL funding and dispatched them toward "high-volume" hospitals in Ikom, Ogoja, and the southern senatorial district.

The volunteers remained in the facilities for about two to four weeks (in Ikom and Ogoja). SMGL has renovated the doctors' quarters in Ogoja to facilitate their permanence there. Travel allowances and per diem were allocated by project.

> *"This year alone, they [Pathfinder] have sent two pediatricians to check us, evaluate us, and to carry out newborn care with us. When they come, they stay like one week, they stay and observe what we are doing and one of those days, all the staff will meet together to carry out the training."* (Catholic Maternity Hospital staff, Ogoja)

For the PHC facilities, SMGL selected retired midwives (usually members of the surrounding communities) to mentor and coach the CHEWs on a daily basis. This mentorship was conducted during

ANC and institutional deliveries, but it was reported as the mentor midwife has supported other PHC activities (i.e., outreach and referrals). The progress on the CHEWs' performances was recorded via a mobile phone application that Pathfinder has used previously in Tanzania/Mozambique for FP. Mentor midwives discussed individual CHEW progress with Pathfinder program officers during monthly meetings. The app was adapted to provide maternal newborn health and EmONC feedback.

For those CHEWs who did not attend SMGL training workshops, the mentor midwife trained them using both the app and the training manual to upgrade the CHEWs' skills. Mentor midwives visited the HF four to five days a week, receiving monthly allowances from Pathfinder. Another role they played was to accompany and follow up with women who were referred to higher levels of care during pregnancy and delivery. They continued to check in with women, after they had returned home, who had experienced serious obstetric emergencies.

It was reported that the midwives also worked with the TBAs (principally on early referrals before the delivery) and collected monthly data on referrals in order to distribute the incentives to the TBAs.

Despite the incentives and the sensitization carried out for the TBAs, a few of them were still delaying women in labor before referring them to the facility.

Referrals and improved interpersonal relations

Forty-five percent of the interviews with the HF staff reported an increase in referrals from the PHC to the hospitals, and between private and public HFs—and vice versa. Improvements in those referrals were attributed to the cluster system put in place by SMGL.

Descriptions of how the project has strengthened the referral network were shared with the evaluation team. The major change observed by the hospital staff was that women and their babies arrived alive because the PHCs are referring in time. Another factor that has improved referrals is the ETS, discussed in the previous section, that is used both to transport women from their homes to the PHC and then to the general hospital if they need a higher level of care.

Additionally, the availability of health providers has changed. PHC facilities and hospitals now have skilled staff available 24/7. The project supported the cohesion between health workers at all levels of care, and the exchange of contact numbers in case of an emergency referral. This approach has improved the interpersonal relations between CHEWs and hospital staff.

PHC staff notify the hospital when a woman or baby needs to be referred and informs them to be ready to provide immediate care after the woman's arrival.

Following the interviews with different HF staff and project implementers, the referral systems sustained by SMGL have been helpful in curtailing maternal mortality in the remote areas while the training has boosted the capacities of the HF staff. The PHC facilities now are more aware of their clinical and treatment "limits" and are eager to refer cases they know are beyond their capabilities to facilities that can handle them.

The method of referrals has improved over time. Previous behavior, such as keeping a patient at the PHC and referring her when in critical condition, no longer exists. The importance of addressing the 3-Ds has sensitized the health workers to act fast and refer the patients in a timely fashion. The availability of tricycles, use of partographs, and mentor midwives who readily recognize danger signs have improved referrals to higher levels of care.

Twenty-five percent of the interviews held with private facilities reported that referrals to them were justified in terms of faster response once a woman arrives at their door, and there was no difference in terms of quality of care. To be competitive with the public HFs receiving the support of the project, private clinics have decided to reduce their ANC and delivery fees. Some private hospitals have also referred to public facilities, when public hospitals are better equipped or staffed with specialists.

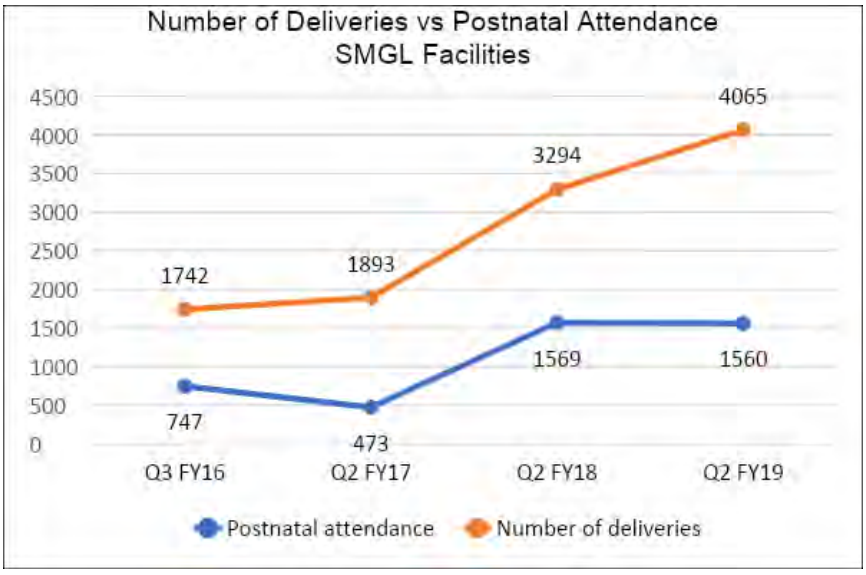
> *"We have seen promptness in responding to cases, timely referrals, proper use of partographs and increase in operative deliveries in those facilities. For example, we used to have a lot of referrals from GH hospitals to here [teaching hospital in Calabar] but now we hardly have those because most of the cases are managed in the facilities."* (SOGON CRS)

Despite the promising results, the counter-referrals and follow-ups were not really fulfilled and little is known about the woman's health after her discharge from the hospital. The challenge is to also follow through with counter-referrals from the hospitals to the PHC so that community health workers and PHC nurses and midwives can provide any needed follow-up care after release from the hospital. This is of particular concern as both the monitoring data and the endline assessment indicate an increase in postpartum sepsis.

Postpartum infections

Data from both the project endline report and monitoring data, show that approximately 40 percent of the deliveries carried out in SMGL-supported facilities were followed up with postnatal care visits. Figure 6 and Table 9 below report on those numbers. Despite the increase in the number of postnatal visits during SMGL implementation, these visits remain low compared with the number of institutional deliveries. Further analysis has revealed that the number of intra-facility maternal deaths caused by sepsis remained steady and did not show any sign of decline as shown in Figure 8.

Figure 6. Comparison between Number of Deliveries and Postnatal Visits



Source: SMGL Monitoring Data

Table 9. Postnatal Care Visits

	Baseline (HFA 2016)	Endline (HFA 2019)	LOA Target	Percentage of change
Number of women attending PNC	3,149	7,298	5,700	128%
Number of women delivering in a facility	13,472	17,727	14,228	124%

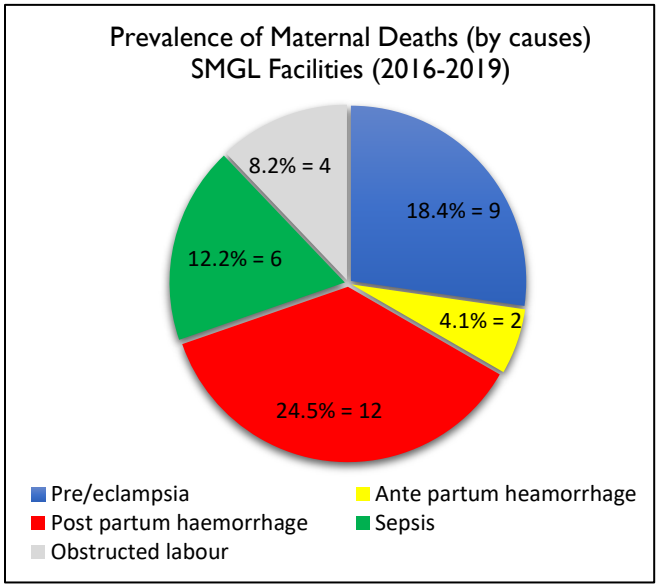
Source: SMGL HFA 2019

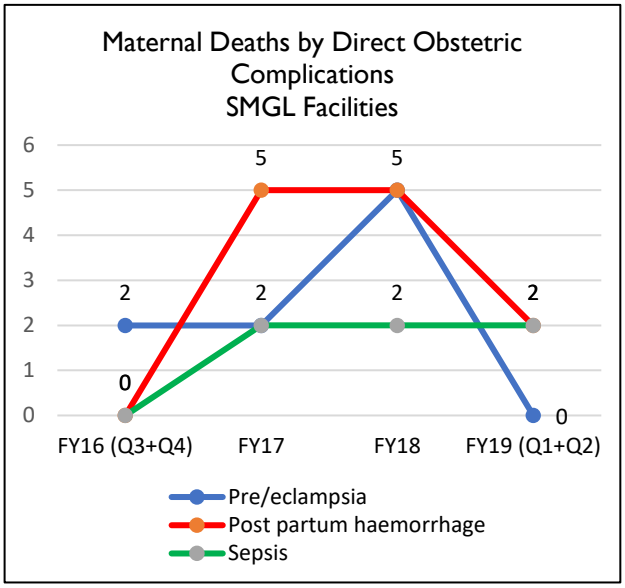
Despite what was reported by the HFA in 2019 (endline) in terms of water availability and functioning systems, during the field portion of the evaluation, the team observed that the majority of the HFs lacked running water or a functioning borehole. Even the few that had systems installed, were not functioning at the time of the evaluators' visits. The evaluation team found the hygienic conditions of the delivery rooms to vary from one PHC to another. The conditions were better where SMGL had done a full renovation and worse where they had not. The pictures to the right illustrate a fairly typical delivery room in a PHC.

Puerperal sepsis is the infection of the genital tract occurring at any time between the onset of rupture of membranes or labor and the 42nd day postpartum.[12] Postnatal follow-ups are critical for identifying cases of puerperal sepsis and to treat them appropriately. Hygiene at birth is one of the first measures to prevent postpartum infections.

[12] WHO recommendations for prevention and treatment of maternal peripartum infections, 2015

Figure 7. Number of Maternal Deaths by Cause in SMGL HFs





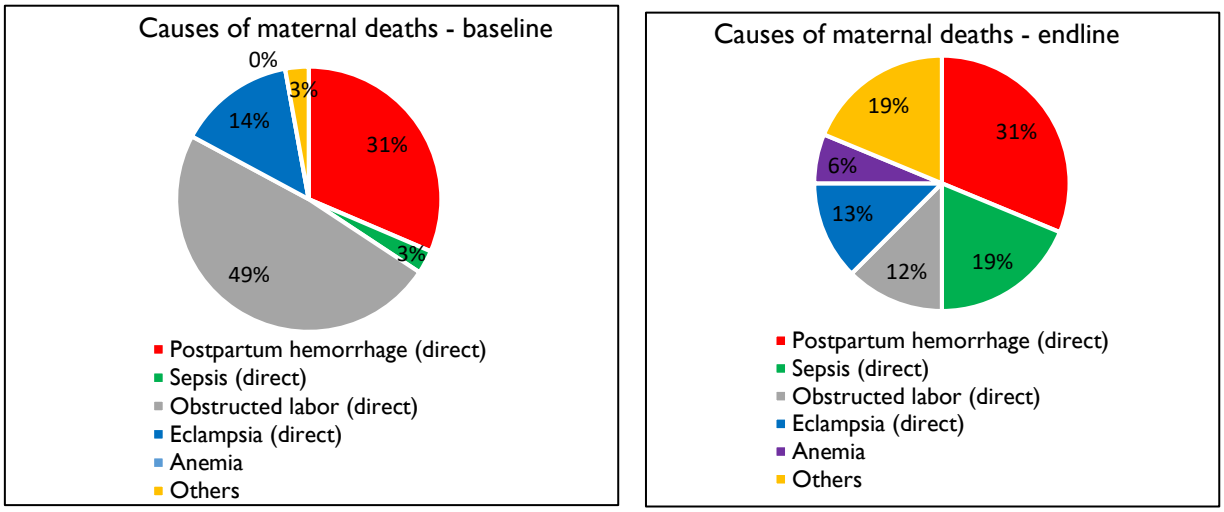
Source: SMGL Monitoring Data

The secondary data on maternal deaths due to postpartum sepsis were corroborated by the results of the endline assessment as shown in Figure 8. Maternal deaths caused by sepsis have increased from 3 percent to 19 percent.

Despite that the project monitoring data show a reduction of maternal deaths due to postpartum hemorrhage and eclampsia (Figure 7 above), data from the endline assessment shows no changes, and deaths due to other causes and anemia raised significantly at the endline. Deaths occurred by obstructed labor were reduced, probably due to the increased use of the partograph and more timely referrals.[13]

[13] The evaluators could not determine the exact reasons for the increase in postpartum infections. Additional investigation could look at where they are occurring and whether there are common contributing factors, such as lack of attention to biosecurity due to lack of water and electricity or other supplies, little emphasis on PPC prior to discharge and within 10 days of discharge, lack of counter referral protocols and follow-through, or cultural practices postpartum that may introduce infections.

Figure 8. Causes of Maternal Deaths in HFs—Health Facility Assessment Baseline and Endline Comparison



Source: Others include ectopic pregnancy, ruptured uterus, retained products of conception, malaria, and HIV

EVALUATION QUESTION 3. TO WHAT EXTENT HAVE COMMUNITY STRUCTURES CONTRIBUTED TO CHANGES IN DEMAND FOR, ACCESS TO, AND UTILIZATION OF QUALITY HEALTH DELIVERY SERVICES IN THE TARGETED COMMUNITIES?

Background

To ensure that pregnant women within the state have timely access to quality maternal and newborn health services, including emergency care in the event of complications, SMGL, through its implementing partners and grants to local organizations, supported the development of ETS. SMGL also worked with and strengthened existing WDCs to provide oversight of the HFs and outreach to communities through the Ward Health Development Committees in the wards with SMGL-supported facilities to provide oversight of the HF and outreach to the community. As described earlier in the report, SMGL also supported CBOs to conduct outreach to groups of women, men, and girl and boy adolescents on the importance of using HFs for ANC, labor and delivery, PPC, and FP. TBAs are other important community actors, which the project engaged to conduct outreach to and referral of pregnant women to the HF.

This section presents findings and analysis of the Evaluation Question 3, specifically, the roles TBAs/Patent and Proprietary Medicine Vendors (PPMVs) played in targeted communities to increase access to quality FP and labor and delivery services. This is in addition to the ways that linkages to HF delivery services increased or decreased in the SMGL-supported facilities. The findings and analysis are presented below.

SMGL engagement with TBAs

Raised Awareness among TBAs:[14] SMGL raised awareness among TBAs about danger signs in pregnancy, labor and delivery, and the importance of referring women to the HF for delivery. SMGL trained TBAs in the targeted communities on danger signs and when to refer pregnant women in labor to the facility. Increased awareness on the part of TBAs, especially their greater knowledge of danger signs and the capabilities of the HFs to resolve complications, has contributed to increased utilization of the HFs by pregnant women. It is also possible that fewer births attended by TBAs also contributed to fewer maternal and neonatal deaths, but SMGL did not collect information on community deliveries or deaths, except in HFs. When interviewed by the evaluators, TBAs demonstrated their knowledge of danger signs by correctly identifying them to include swollen legs (indicative of pre-eclampsia, hemorrhage [bleeding], and prolonged labor).

Because TBAs are influential members of their communities, changes in TBAs' increased knowledge, awareness, and practices as promoted by SMGL appear to have influenced TBAs' interactions with pregnant women and their families. Many have persuaded pregnant women and their partners to utilize the HF for delivery. While not all TBAs have abandoned attending births, a significant number were convinced by the training and additional incentives to play a new role as health escorts to accompany pregnant women to ANC registration and delivery. In some cases, healthcare providers also incorporated TBAs into the delivery process by letting them act as companions to women during delivery and assisting health workers with nonclinical tasks.

Although overall, the TBAs interviewed for the evaluation saw SMGL as a very positive experience, they expressed concerns about the actions of other TBAs in communities outside the influence of SMGL, as well as voicing the challenges that they are likely to face as a result of their new roles. Foremost among their concerns was the inconsistency in stipend payments for escorting women to the health services. They stated that the terms on which they were to be paid were not clear and consistent, and they implied that not all TBAs were treated equally. SMGL started the stipend payments in 2018 according to project staff interviewed, with the intention of offsetting TBA's loss of income from providing delivery services. As can be seen from the quotes below, there was a great deal of confusion about the payment scheme.

> *"When SMGL engaged us [TBAs] in late 2016 and early 2017, they said that if any of us [TBAs] brings a pregnant woman in labor to deliver at hospital [PHC] nearest to us, an amount of N3,000 will be given to the person [TBA] . . . and because of that we have been bringing women to deliver here [PHC], but the problem is that some of us will be paid and some will not get their money. . . . In fact since second quarter 2018 up till now, I have been bringing women to deliver here [PHC] and I will fill the form and no payment up till now."*

> *"In 2018, majority of us [TBAs] that brought pregnant women in labor to deliver here [PHC] have not been paid, although they paid some [TBAs] in 2017 . . . but since the beginning of this year [2019] none of us [TBAs] has received kobo for bringing a pregnant woman to deliver her baby here [PHC] . . . the completed forms are here with Nurse Vero."*

[14] TBAs as a category are a very heterogeneous group. SMGL conducted a qualitative study of TBAs and found that it was a diverse category encompassing indigenous birth attendants, faith-based birth attendants, and TBAs trained by the health services. The evaluation team was told by healthcare workers that even some retired midwives and nurses, who provide services in their homes, are considered TBAs as well.

The 2019 SMGL report on TBAs emphasized some of the reasons women and their families preferred to be attended by TBAs rather than the health services. These include cost, but more importantly, the timing of payment and types of payments. TBAs did not demand payment upfront, as do the health services, and were willing to take payment in different non-monetary forms (SMGL 2019).

TBAs as Escorts: TBAs act as escorts for women in labor to deliver at HFs. The SMGL project engaged with TBAs through training and coordination. In 2018, the SMGL staff also began to remunerate TBAs for escorting women to SMGL-supported BEmONC and CEmONC facilities at a rate of N3,000 for each woman escorted. The rationale for the stipend was that TBAs needed an economic incentive to offset the loss of income from foregoing attending deliveries at home. The initiative appears to have encouraged TBAs to support women's use of the health services and to escort them to the PHC once they are in labor for delivery in lieu of home births.

> *"In the several training workshops that were organized by Pathfinder that we [TBAs] attended, the trainers have continued to tell us not to be accepting deliveries at home and also that we should try to be sensitizing pregnant women in our communities to go [ANC] . . . and even after delivery they [the women] should try and carry their babies to the HF for checkup [PPC] . . . That has been the work our people [TBAs] have been doing with Pathfinder since that time."* (TBA, Ibil)

Based on information collected from interviews, as well as from reviews of medical records and the partographs, there are still challenges in ensuring that TBAs and other decision-makers about women's use of the health services make the decision early enough in labor to ensure that the woman reaches the HF early. Many partographs reviewed for the evaluation indicate that women arrive quite late in their labor, often risking not arriving at all.

TBAs also expressed mixed feelings regarding payment of the stipend. At the initial stage of the initiative (exact times vary across different communities), TBAs reported being paid when they escorted a woman in labor to the facility. At some point (in 2019), TBAs and CHEWs stated that payments to TBAs began to be delayed and they have not received any payments in the last few months. Most TBAs interviewed said that the lack of payment would not deter them from continuing the escort services because they are more interested in saving mothers' and babies' lives. However, others reported the need for an alternative source of income, especially if they no longer accept deliveries at home and don't receive the stipend from SMGL.

A majority of the TBAs expressed their inability to self-finance these activities even though they recognized the significance of contributing to increased demand for, access to, and utilization of healthcare quality services. The underlying implication at the close of SMGL is that collaborations between the HFs and the TBAs will begin to weaken with the consequence of some women reverting to opting for TBA rather that HF-assisted births.

> *"We do carry out joint sensitization campaigns with Greater Hands Initiative [GHI] on health talk across the different villages in Ikom, and each time we are going for such sensitization, Greater Hands Initiative usually provides our members with minerals, snacks, and transportation of N500 for each TBA participants . . . so now that they said SMGL is closing I*

am not sure whether GHI can continue to support that kind of sensitization campaign." (TBA president, Ikom)[15]

Similarly, another TBA participant expressed her worries over the sustainability of their activities and stated that:

> *"You know that most of us depend on the TBA work for survival, and as Pathfinder introduced the N3,000 money for anyone who takes a woman to deliver at the facility, I was very happy. But since they [Pathfinder] stopped paying, and they said we should not accept deliveries again . . . how can one survive without any alternative for income generation . . . something needs to be done for us [TBAs] who have decided not to be accepting deliveries at home."* (TBA, Ikom LGA)

HF staff also voiced concerns in some of the HFs visited about compliance of the TBAs with the SMGL's initiative. For instance, in Ibil, the HF staff reported lack of cooperation and continuous resistance from some of the TBAs engaged by SMGL. The facility currently works with only a few TBAs in promoting the escorting service, sensitization, and coordination of women on utilization of the HF for ANC, FP, labor and delivery, and PPC in the community.[16] The CRS MOH has promised to take over the stipend program by using funds from the World Bank SOML, but the new program is not yet operational. In the interim, there are indications that some TBAs may revert to earlier practices if stipends are not forthcoming.

TBAs and FP: Another new role that TBAs adopted was to discuss FP with pregnant women's partners through home visits to encourage men to allow their partners to accept PPFP. They strategically visited them when the women were not home in order to have private conversations. The TBAs interviewed by the evaluation team reported mixed results from their outreach on FP, particularly with pregnant women's partners. While women stated that they now had greater knowledge about FP services from their ANC visits, the TBAs were less successful in changing men's attitudes.

Several TBAs reported instances where women who were escorted to deliver at the HF did request FP immediately after delivery, and that this was new, as prior to SMGL most women did not. Similarly, the TBAs reported to have sensitized adolescents [school age] groups, particularly the girls in the communities, on FP services. They stated that access to FP has allowed girls to stay in school longer, increasing the number of adolescent girls completing secondary school compared to the time prior to SMGL. They also said that there are fewer deaths from unsafe abortions, and fewer unplanned adolescent pregnancies in their communities.

[15] GHF was one of three non-governmental organizations (NGOs) that Pathfinder contracted to do community outreach work.

[16] They suspected that TBAs continued to accept some deliveries at home without reporting them.

"I have severally undertaken house-to-house visit when mostly household women may have gone to markets to speak . . . and I believe my co-TBAs also do. We visit these households to sensitize the husbands on family planning . . . we advise them to support their wives to utilize FP services . . . and we also tell them the importance of FP . . . in some cases you find them accepting and otherwise in some cases. But I am very happy that women themselves are now the ones demanding for FP services when they deliver at the facility." (TBA, Ikot Nakanda)

Coordination of TBAs with WDCs, PHCs, RLs, and **Village Chiefs (VCs) on Outreach and Sensitization:** SMGL facilitated coordination of TBAs with other local actors, including WDCs, VCs, RLs, and HFs in sensitization and escorting pregnant women to use HF, particularly for ANC, FP, labor and delivery, and PPC. The TBAs reported having been part of several meetings predominantly facilitated by WDCs, where the discussions focused on the expected role of each stakeholder in the sensitization and coordination of pregnant women in the communities toward utilization of the HFs for ANC, FP, labor and delivery, and PPC. The WDCs and TBAs reported that collaboration by the TBAs with other stakeholders was influential in stimulating the changes in pregnant women's health-seeking behaviors that contributed to increased demand for, access to, and utilization of quality healthcare services. Some TBAs expressed the view that their role was the most influential of all because of their special connection to pregnant women.

Group interviews with TBAs from Ikom LGA

Linkages between communities and HFs

SMGL capacity building of CHEWs and WDC oversight of PHCs contributed to increased utilization of services and more respectful care for women by healthcare providers. SMGL built capacity of WDCs and strengthened collaboration between WDCs, VCs, and PHC staff that stimulated the use of town halls for meetings. This brought PHC staff into the community and helped cement relationships. SMGL engaged WDCs across the targeted communities to manage the ETS initiative, coordinate meetings of key actors in communities, and facilitated improved relationships between the community and PHC staff through adequate utilization of town hall meetings, all with a view toward realization of improved maternal and neonatal healthcare in the communities. WDC members who were interviewed reported increased capacity in advocacy and community engagement skills, including "SMART" advocacy, which entailed raising money through awareness-building and outreach to influential ethnic and religious leaders in the communities. WDC members reported being able, in most communities, to effectively engage with the larger community in sustaining SMGL initiatives, including ETS management, sensitization, and coordination of key stakeholders, including TBAs, VCs, RLs, and pregnant women toward increased demand for access and utilization of HFs for quality healthcare.

The WDC monthly meetings[17] involving several key stakeholders have improved coordination among stakeholders while also aiming to amplify advocacy and sensitization for increased utilization of HFs for

[17] Reported in most of the facilities visited.

ANC and labor and delivery. The increasing involvement of PHC staff at townhall meetings was reported to have contributed to an improved relationship between the PHC staff and the general members of the communities. Through the town hall meetings, PHC staff reportedly have sensitized the community members toward effective utilization of HFs for quality healthcare services. Some communities reportedly hold their monthly town hall meetings at the PHC premises, involving the PHC staff and other key stakeholders. For instance, during a group interview, the WDC Ugep reported that it holds its monthly meeting within the PHC. They stated that this regular interaction has been an important mechanism for working together to improve healthcare services in the Ugep community.

SMGL facilitated greater use of the PHC as educational platforms for ANC, delivery, and FP, making PHCs a more familiar place for the surrounding communities. Interactions between the WDC and the PHC also encouraged health workers to conduct educational activities in communities, schools, and at the PHC. They provide individual education and counseling through ANC and FP visits, but they also address health issues in the community. The staff from many PHCs stated that they use town criers from the WDC to alert people to PHC-sponsored meetings at the facility and in the community. For example, CHEWs from PHC Mkpani regularly conduct community meetings to speak to youth and teachers at schools, market women, pregnant women, and others at town hall meetings. During their outreach activities they do HIV testing and counseling, identify pregnant women, and speak about how to reduce the incidence of cholera and prevent malaria through the use of bed nets as well as about the value of spacing pregnancies and FP. At PHC Ikot Omin, the Head CHEW organized free clinic days once or twice a month to encourage people to come into the PHC. On those days, they also offer educational talks on different health topics.

Through the WDC, SMGL facilitated the creation of the ETS, which was an important nexus between community and facilities. Although support varies from PHC to PHC, some look more sustainable than others. The majority of WDC members interviewed noted that SMGL supported the WDC to create and coordinate the ETS and address delay 2 in getting women in labor or experiencing complications to HFs for quality healthcare. Reports indicated that SMGL financially supported WDC with the sum of Naira 50,000 if the WDC was able to generate counterpart funding from local contributions for running the initial phase of the initiative. Depending on the distance, an ETS driver is paid between Naira 500 and Naira 1,000 for motorcycle riders, and Naira 2,000 and Naira 2,500 for vehicle owners.

The money is paid by the healthcare workers who are given funds by the WDC to pay drivers when they arrive with women in labor. In other instances, the HF staff provide a voucher which is paid by the WDC. Evidence also emerged showing how some of the communities have leveraged—through "SMART" advocacy—additional funds for the ETS, an initiative considered innovative in the sustainability of the system. In other communities, the WDC members contribute from their own resources. Another model taxes chiefs by a monthly amount set by the WDC. The taxes go into a revolving fund to pay ETS drivers. In Ugep (Ogoja LGA), the community leader made a pronouncement (i.e., a local law) mandating that every villager in the community contribute a monthly amount of Naira 1,000 into the ETS fund. Similarly, in Emangabe community of Ikom LGA, the "Paramount Ruler" also made a

pronouncement mandating the 12 villages comprising Emangabe to contribute Naira 2,000 monthly into the ETS fund.

Although precise practices vary across communities, not all the communities visited had developed sustainable solutions and may run out of money once the Naira 50,000 donation is used up. In some communities, the ETS drivers are immediately paid upon completion of their service, while in some communities, it reportedly takes several days to get paid. This condition was described as discouraging in the affected communities.

While the ETS has proven to be effective in addressing delay 2—getting women in labor or with complications to HF—there are some challenges to sustainability. First, ETS has become a routine form of conveyance for all women in labor, not just for those experiencing emergencies. Second, not all WDCs have developed adequate funding mechanisms. Third, irregularity in payments to ETS drivers in some areas may discourage them from continuing to provide services. There were also questions about whether the amount they are paid is adequate to cover their costs.

EVALUATION QUESTION 4. TO WHAT EXTENT HAS SMGL INCORPORATED GENDER STRATEGIES TO IMPROVE ACCESSIBILITY AND UTILIZATION OF SERVICES?

General findings

SMGL had aimed to integrate gender into its design and approaches in response to findings from the First Time Parents (FTP) Study (E2A 2018). The study revealed the importance of engaging male partners for eliminating delay 1. The study also made clear that older women played a crucial role in guiding young women's decision to utilize maternal and newborn health services. FTP was implemented in only two of the 18 LGAs where SMGL had a presence, Ikom and Obubra. The evaluation team conducted interviews in Ikom but not Obubra.

The evaluators were not able to locate a clear statement on the objectives of a gender integration strategy based on an assessment of gender roles, responsibilities, practices, beliefs, and decision-making in the different ethnic groups and communities of CRS that constitute constraints to women being able to access and utilize life-saving MNH services, especially when they experience complications during pregnancy, labor and delivery, and postpartum.

SMGL gender programming aimed to incorporate strategies to address gender-based constraints to accessibility and utilization of services. There were two types of interventions aimed at addressing gender inequalities in the program. First, a gender module was included along with CHEW training on BEmONC and LARC. Second, one CBO, the GHF, implemented community-level social and behavioral change communication for first-time pregnant women and other influential decision-makers, such as their partners and older women, who were mothers or mothers-in-law. The GHF initiative was a limited but more substantial intervention than the training modules, but was restricted in reach to the central senatorial district of the state. The educational sessions were delivered by community volunteers to groups of young women and separately to young men. The FTP intervention sought to empower young women to make "informed" personal decisions about their reproductive and maternal health, including decisions about where to register for ANC, give birth, and get service for their newborn babies and on FP services. For men, FTP focused on building awareness about the benefits of ANC, labor and delivery, PPC, and FP in an HF. Additionally, as the research indicated that men were the main decision-makers, FTP tried to influence them not only to make the right decision, but also to make it jointly or in consultation with their partners. It was assumed from the FTP program that engaging men to change

their attitude and become more responsive to supporting women's access to maternal and newborn care as well as FP service was key to changing the gender norms and attitudes of men, who were typically aloof during pregnancy and childbirth.

Despite the training and limited FTP intervention, it was difficult to find a clear gender approach or strategy for the SMGL project. Many of the implementing partners and healthcare workers acknowledged that women have rights that they could not act on because of existing gender relations, beliefs, and practices. Nevertheless, they considered that addressing gender-based barriers was not critical to achieving the objectives of the SMGL, as the project already focused on women and their babies. This was evident from a review of the quarterly reports, which inserted the same paragraph in every report and listed one or two interventions without any associated indicators. As required by ADS 201 and 205, the SMGL quarterly reports provided sex disaggregated data on attendance in meetings, community events, and training courses. They did not analyze the information to discern whether the proportional participation of men and women in different events and courses revealed gender inequities in access nor did they provide information on how they were addressing gender inequalities in programming. The standard paragraph that appeared in every quarterly report was:

> *Gender Equality and Female Empowerment: "To the extent possible, all project activities are implemented with gender equality in view. All data where possible is disaggregated by age and sex, with trainee selection done with greater consideration given to female providers, considering the somewhat difficult relations female clients and male providers may experience especially in rural communities." (e.g., January–March 2018 quarterly report)*

During trainings, some level of gender equality issues was embedded into trainings for CBOs, ETS drivers, and healthcare providers at the facility, but there was no measurement of outcomes. Yet, when questioned about what to do if a woman confided to a health worker that she was experiencing violence in her home, several health providers responded that they would bring the husband and wife in to talk. This strategy potentially puts the women in danger of escalating violence. A few CHEWs, when interviewed, mentioned that the gender training modules made them aware of women's rights and that women were entitled to quality and respectful care. They said that the instruction had positively influenced their interactions with women during ANC and delivery.

> *"There was also a curriculum for training FTP. It was a 14-session curriculum, which had sessions on positive parenting, FP, exclusive breast feeding, gender-based violence, etc."*
>
> *"We integrated gender into the training curriculum for CBOs and healthcare providers at the facilities."* (Pathfinder staff member)

There were no gender-related indicators that could be traced to the project document. This was particularly difficult because it means the project did not have gender-related baselines aside from the fact that all data were disaggregated by sex. This means the changes—positive or negative—could not be tracked using the available M&E tools.

> *"There was no gender staff allocated to the project. The project did not have resources to hire a skilled person in that regard. A gender person at Pathfinder HQ was giving support at the early part of the project but had to discontinue because of other priorities."* (Group interview, E2A/SMGL leadership, Abuja)

There were notable changes with regard to change in behavior for women, especially in accessing ANC, giving birth at the facility, and accessing FP services. During the field visits the evaluation team also noticed some changes in the men as regard to supporting their partners' access to ANC and giving birth at the facility, though the team struggled to understand the dynamics of joint decisions in accessing FP services.

Aspects of the projects that are crucial and central to achieving project goals require adequate financial resources and expertise. SMGL had inadequate technical skills among the staff allocated to the project. There was no gender staff on the project, nor did Pathfinder have a gender-related staff member in their Abuja office to support the project. They relied on infrequent support from the gender advisor in the E2A office in Washington, DC, who had little time to dedicate to the project. This was visible in the lack of approach and direction in all gender-related activities on the project.

Changes in gender roles and relationships during SMGL

The most tangible evidence of a factor that contributed to increased use of ANC and delivery services were women's perceptions that healthcare workers' attitudes had improved, and that CHEWs, nurses, and midwives were friendlier and more welcoming than before. It was visible in the interviews that the number of women accessing ANC, and also those delivering at the facility, had increased due to the change in attitude of health workers. Statements by women who had had a baby in the health services in the last year, their partners, and older women whose daughters or daughters-in-law had given birth in the last year coincided with the health workers' self-assessments that their interactions with clients had changed. Some health workers attributed this change to insights they had gained through the gender training provided by SMGL.

> *"The PHC health workers are now friendly and attend to people more politely than before where they were rude and shouted a lot at people. They also refused to take in women who did not register for ANC. Because they were nice to women, more women were willing to attend and can deliver at home."* (Older woman, Idundu)

> *"We attended all our ANC appointments without missing any because the health workers normally called to remind us of each appointment."* (New mother, Akpabuyo)

A number of women accessing ANC and delivering at the center cited both the change in attitude of the health workers and the incentives they received, such as soap during ANC and Mama Kits for delivery, as the reasons they had registered for ANC and delivery at the PHC.

> *"Women use the facility to deliver safely and are well cared for; delivery at the healthcare facility is almost free; when the women deliver at the hospital, they are given towels, soaps and other gifts."* (Male partner, Idundu)

In contrast, there was little information on whether changes in gender roles and relationships among women and their partners had contributed to greater uptake of health services. SMGL did not track who made the decision to seek care at the facility, and whether it was a decision made by women, men, or jointly. The interviews conducted by the evaluation team did reveal some areas where there appear to be incipient changes. Young women and their partners indicated that young men now show more—and earlier—interest in newborns than before. Some women stated that their spouses accompanied them for ANC and encouraged them not to deliver at home. They said this was due to various factors, ranging from good health services, women's lives being saved, and getting more information from healthcare providers. In the group interview in Ekumtak, the men all affirmed to have been involved in

their partners' pregnancy until delivery. When asked to specifically describe how they were involved, they mentioned different activities and support, including:

- Taking their wives to register for ANC
- Ensuring that their wives go to their ANC appointments
- Assisting with home chores
- Purchasing medications as prescribed
- Ensuring that their wives take the medication
- Facilitating trekking exercise to ease delivery [a general belief that a woman about to deliver should be made to walk around as a form of exercise], supporting her emotionally, and accompanying the wife to a healthcare facility for delivery

One pregnant woman's partner in Indundu said he was involved in registering his wife for ANC, buying her drugs, and transporting her to attend ANC at intervals. He further mentioned that he brought her himself to the facility for delivery. Another pregnant woman's partner said prior to SMGL he was a serious advocate of TBAs delivering at home or at churches, but all that has changed now. In the past, he provided TBA support to his wife, particularly the church, but now those supports are no longer happening, as he now encourages his wife to make referrals and orients pregnant women to use healthcare facilities for ANC and delivery.

Changes in men's and women's decision-making power

While reviewing reports from the FTP program, the evaluation team noticed that GHF had integrated a number of men's involvement activities into their program. GHF observed that gender inequality is a deep-rooted issue in CRS, making it difficult to see women making decisions about pregnancy-related issues. They observed that men made most pregnancy and FP decisions. But due to GHF activities with men during the FTP program, they observed that some men have started involving their partners more in decisions relating to pregnancy and childbirth. GHF shared examples of men who previously had left the burden of work to women after childbirth and some women were violently abused by their partners for not being able to care for their child and cook meals as quickly as possible. GHF said they witnessed drastic changes in men's attitudes and practices—they were more supportive of their wives as new mothers, especially in assisting with the care for the newborn. Some men confessed they had not done this previously as they were afraid of being viewed as not "manly." GHF stated in the interview for the evaluation that the overall attitude of men has changed to treat women better. The GHF quarterly reports to Pathfinder are consistent with the findings from GHF's interview.

The GHF intervention on FTP was not fully integrated into the rest of the SMGL strategy. Where CHEWs, WDCs, TBAs, and other CBOs conducted outreach, they lacked clear messages and techniques for engaging men and women on changing gender roles and decision-making.

Changing attitudes in accessing FP was a component in the SMGL project. It was expected that gender roles be integrated into strategies or activities that would increase access to FP services by women and change the attitudes of men to be more open and encourage joint decision in access to FP services.

During the field interviews, the CBOs confirmed that access to FP services was a huge relief to young women in preventing pregnancy. Women were excited to know they could access FP services right after

delivery. CHEWs informally estimated that about "30 percent of women who delivered at a healthcare facility accept FP immediately after delivery." Leadership at both GHF and Center for Healthworks, Development, and Research (CHEDRES), another CBO operating in the southern senatorial district of CRS, observed that some women had started making FP decisions for themselves at the HFs. CHEWs said in their interviews that one of the reasons that implants were so popular is that women can use the method without their partner's knowledge. GHF attributed increased uptake of FP by women to the influence of their activities with first time mothers who were told it is their right to choose which FP method they wanted and where they could access it. Some women are able to make FP decisions based on the information they now have as a result of the sensitization carried out by GHF. Women were persuaded by the message that "after giving birth women should wait at least three years before giving birth to another child." CHEDRES also stated that it was clear that women were asserting themselves in the area of FP. Nevertheless, both organizations stated that most men still make the final decisions on where and how to access these services. The WDC members in Idomi, Yakur, stated that husbands are the greatest barriers to women registering for ANC as they claim it goes contrary to the way their mothers delivered at home. They are also a barrier to the use of FP.

In contrast, WDC members interviewed in LGA Ikot Nakanda said that when men and women do accept FP, men become more faithful to their wives, since their sexual relations improve as the women no longer worry about becoming pregnant when they do not want to. They said that the use of FP to delay the next pregnancy has also reduced HIV transmission in the community.[18]

EVALUATION QUESTION 5. TO WHAT EXTENT HAVE STATE AND LOCAL AUTHORITIES MADE PLANS TO SUSTAIN SMGL'S INTERVENTIONS AND ACTIVITIES IN CRS?

Background

SMGL staff stated that they had a transition and sustainability plan from the start. While there is a document dated October 30, 2018, titled "Activity Close-out Plan October 1, 2018–September 30, 2019," the list of activities to transition to state government is daunting.

It should be noted that SMGL was not developed with a strong emphasis on sustainability, but rather as a proof of concept that addressing the 3-Ds to women accessing life-saving care during pregnancy, labor and delivery, and postpartum will reduce maternal and neonatal deaths. In all three countries where SMGL has been implemented—Nigeria, Uganda, and Zambia—the hypothesis has been borne out by demonstrating a 38 to 44 percent reduction in MMR. In Uganda and Zambia, SMGL conducted population-based surveys at baseline and endline to measure MMR, in addition to measuring facility-based case fatality rates and extrapolating institutional MMR and NMR. In Uganda, institutional MMR decreased by 44 percent from 534 maternal deaths/100,000 live births in 2012 to 300 maternal deaths/100,000 live births in 2016. The Uganda institutional perinatal and stillbirth mortality rates both decreased by 13 percent and pre-discharge institutional NMR decreased by 10 percent. During this same period, community MMR in Uganda also decreased by 44 percent from 452/100,000 to

[18] There were many actors in CRS providing FP and HIV services. The evaluation team heard recurring accounts by both women and men about reductions in adolescent pregnancies and HIV as a result of increased access to FP. During the evaluation it was not possible to validate these findings quantitatively, or to attribute them to SMGL. The evaluation team's qualitative data collection revealed that reductions in HIV and early pregnancies was a frequent observation made by a cross-section of interviewees, including women who had recently delivered in an HF, their male partners, CHEWs, TBAs, and WDC members.

255/100,000. In Zambia, the decrease within this time frame was slightly less for MMR: a 37.6 percent drop from 370/100,000 for institutional MMR and a 40.8 percent decrease for community MMR. The decreases for infant-related death rates in Zambia were greater than in Uganda. Institutional perinatal mortality and stillbirth rates decreased by 26 percent and 36 percent, respectively. Total pre-discharge NMR, however increased by 14 percent (Morrissey Conlon et al 2019: S17).

According to the Nigeria Endline Assessment, the decrease in institutional MMR was reduced by 66 percent from 313 maternal deaths/100,000 live births to 106 maternal deaths/100,000 live births, and institutional NMR fell by 47 percent from 58 neonatal deaths/1,000 live births to 3 neonatal deaths/1,000 live births. The project monitoring data, however, do not show a clear decrease in number of deaths.

The SMGL had a goal to reduce facility MMR by 25 percent and NMR by 35 percent from the baseline values by 2019. Table 10 shows that the project surpassed this goal by reducing MMR by 66 percent and NMR by 47 percent.

Table 10. Achievement of Project Goals in 98 of 108 SMGL-Supported Facilities[19]

Indicator	Baseline[1]	Endline[2]	% change
Facility MMR per 100,000 births	313	106	-66%
Facility NMR per 1,000 live births (pre-discharge)	58	31	-47%

[1] Jan–Dec 2015 (73 facilities), Jan–Dec 2016 (24 facilities), Jan-Dec 2017 (11 facilities); [2] April 2018–March 2019 (108 facilities)
Source: Pathfinder, June 2019.

The effectiveness of the plan depends on its adoption by the government of CRS, its political commitment to SMGL achievements, its decision and capacity to commit adequate resources, and its capacity to manage them effectively and efficiently. The findings in this section highlight the areas that are likely to continue, as well as raise concerns about components of the project that are less likely to be sustainable based on information available at the time of the evaluation.[20]

Critical needs met by SMGL

SMGL Management and Implementation: All stakeholders interviewed, especially Pathfinder's implementing partners, regarded the project as very well managed. According to stakeholders, the dimensions of the project where management and supervision by SMGL was most important are:

- Training of trainers and step-down or cascade training and related CHEW task shifting
- Midwife and doctor mentorship programs
- Regular supervision from Pathfinder

[19] The comparison numbers raise questions about how the institutional MMR was measured in Nigeria. Baseline was collected at two different periods of time and it is not clear what the reference time period was for calculating MMR in either baseline or endline. It is therefore virtually impossible to compare outcomes in Nigeria with those obtained in Uganda and Zambia. The significance of MMR was also not provided in any of the three countries.

[20] The criteria used by the project to infer which components are likely to continue to be supported by the MOH or PHCDA or by healthcare workers themselves came from the evaluation team's assessment of the frequency of certain assertions by a cross-section of stakeholders. The MOH PHCDA were particularly interested in trying to sustain activities that were concrete, visible, and universally praised, such as the Mama Kits, and HelloMAMA. Other interventions had their champions as well, such as the continuance of MPDSR, monthly data review meetings, and the ETS.

- Monthly LGA data meetings and quarterly cluster coordination meetings

Medical professionals highlighted the management of training of trainers' workshops and the efficiency of the cascade training, supported by the medical societies and midwife mentorship schemes. The training of trainers was discussed under Evaluation Question 2 above. In addition to the content, stakeholders highlighted the effectiveness of the delivery, the sustainable decision to train and use local trainers from the teaching hospital, medical societies, and government officials of CRS MOH and CRS PHCDA. Pairing the cascade training with mentorship was also highlighted by stakeholders as a key to its effectiveness. The part of the training that was less sustainable was the high costs of per diems/stipends and hotels for the participants.

The midwife scheme, with its cellular mentor application (app), was particularly praised by health workers and CRS MOH and CRS PHCDA, as it was key to supporting task shifting for CHEWs. This expanded access to services for women and ensured that those services would adhere to evidence-based practices supervised by skilled and experienced midwives. In the PHC Akani-Esuk, the CHEWs highlighted the roles of the mentor midwives:

> *"The mentor midwife works for Pathfinder. She is a mentor that coaches and supervises the work of CHEWs in ANC, delivery, and FP. She reinforces skills of CHEWs in areas that they are not confident. She identifies where there are gaps in their practice and makes a plan for improvement. She uses a mentor midwife app on those skills. For CHEWs that have not been to training, she [the midwife] uses the app and the CHEW [training] manual to train them on proper practice. She visits the facility four times per week. On each visit she fills in a log that is signed by the Head CHEW. She also conducts outreach services to mobilize pregnant women and tracks their progress during pregnancy for all women who are 34 weeks or more. She encourages the Senior CHEW to visit them in their homes."* (PHC, Akani-Esuk, Calabar)

While the doctor mentorship implemented by SOGON and NISONM was also well regarded, there were more challenges in finding staff to mentor as the public general hospitals are severely understaffed, and the healthcare providers on duty are too busy to benefit from mentoring. One mentor doctor explained:

> *"For example, some general hospitals have just one anesthetist. There are days when we go there that they have 10 surgeries and by midnight they will be exhausted because we render 24-hour services. We try our best to train them and mentor them. Also, some of them are still backward in skill acquisition. They have only basic medical training."*

Other challenges to the SOGON- and NISOMN-supported mentorship programs included kidnapping of medical doctors in some parts of the state and inter-communal conflicts that affected the ability of mentor doctors to work in some hospitals. Representatives of the professional societies suggested that future projects might overcome some of these problems by engaging more directly with the CRS MOH and other parts of CRS government to work on the staffing shortages in the public sector.[21] They

[21] Unlike the mentor midwives, the mentor doctors are specialists in neonatal pediatrics and gynecology and obstetrics from teaching hospitals and are not members of the local communities where they mentor. They are part of the FMOH not the CRS MOH. Consequently, they require housing and other financial support, such as per diem. The mentor midwives live in the communities where they work and receive a stipend from PF. With the closure of SMGL, the mentor-midwives will no longer continue their work unless they do so on a volunteer basis.

specifically referenced having access to safe housing, while participating as mentors. The mentors did not encounter similar problems with private hospitals who took full advantage of the mentoring programs.

Both programs face challenges to sustainability. As of yet, there are no plans by the CRS MOH or the CRS PHCDA to continue to fund the mentor midwives. The expectation is that current nurses and midwives at PHCs will assume responsibilities formerly pertaining to mentor midwives. Not all nurses and midwives have been trained, and there are no provisions to continue to pay for the mentor midwife app. The teaching hospital in Calabar is supporting mentoring by deploying resident doctors for discrete periods of time to CEmONC hospitals throughout the state, but the same challenges face these doctors as the volunteers from the professional societies.

Pathfinder played oversight and management roles for SMGL that were critical to the effective functioning of the project, but which may not be adequately adopted by state government in the future. Leadership of both the CRS MOH and the CRS PHCDA complained that Pathfinder had not adequately incorporated them into the management structure. Pathfinder countered that they met regularly with both state entities to discuss implementation. There was more direct modeling of these practices at the local level. These included their hands-on supervisory role and their oversight of data quality and reporting. While two technical advisors from the CRS PHCDA in RH/FM and MNH participated in some of the project supervisory visits, it is doubtful they can continue to provide supportive supervision at the same level of intensity as the project staff. They are also responsible for providing supervision for 712 public PHCs, almost seven times the number of PHCs. It is likely that the intensity of the management and oversight exerted by the project is not easily replicable by either the MOH or the CRS PHCDA without a dedicated staff organized similarly to the project, with regional clinical and M&E project officers in each senatorial region.

Supportive supervision from project staff on clinical and community activities provided an important dimension of accountability to SMGL activities and investments. For example, AGPMPN named an executive committee to visit and evaluate private facilities in all three senatorial districts of CRS. They did this as a substitute for the CRS MOH, which did not have the capacity to evaluate private facilities outside the city of Calabar. SMGL staff conducted regular supervision visits to BEmONC and CEmONC facilities supported by SMGL. They used these visits to reinforce skills learned in training, emphasize the use of data for decision-making, and advocate for sustainable mechanisms for the transfer of knowledge to new health workers and funding of the ETS at the local level.

At the state level, SMGL staff advocated for continuation of incentives for TBAs to escort pregnant women to the HFs, and for pregnant women to attend ANC and delivery services (e.g., soap and Mama Kits), as well as for a continuation of HelloMAMA messaging services.

SMGL program staff also supported quarterly cluster meetings to coordinate and review performance. Heads of PHCs (BEmONC) and general hospitals (CEmONC) commented on the effectiveness of the SMGL cluster model that grouped PHCs with a general hospital for referral. The project staff facilitated quarterly cluster meetings, which focused on analysis of health information, quality improvement progress, and discussions of maternal and neonatal death and near-miss audits as a quality control measure. The clusters consisted of public and private CEmONC hospitals and the BEmONC PHCs that referred to them in an LGA. SMGL paid for transportation and per diem during these meetings. While the heads of PHCs (BEmONC) and second-level hospitals (CEmONC) emphasized the importance of these meetings, they were concerned that the incentives to attend may be reduced. Another challenge,

according to SMGL staff, is that the cluster model is an invention of SMGL that is not a formal organizing structure of the Nigerian health system, nor in CRS, except in LGAs where SMGL was active.

Data Collection and Reporting: Data collection was done at the facility level. Data were entered daily into national and Pathfinder registers by service providers in the HFs. At the end of the month, the M&E/health records officers collated data and entered them into an MSF. The LGA M&E officers usually picked up the filled and signed forms from HFs each month. Once SMGL established monthly LGA-level data validation meetings, the heads of facilities or the facility M&E designee brought their data to the meeting. LGA M&E officers entered the data into the National Health Management Information System (DHIS 2.0) platform. Pathfinder M&E officers also picked up a copy of MSFs from facilities or monthly meetings and entered manually the data into the Pathfinder database that is housed and managed in Abuja. Monthly data validation meetings greatly improved the regularity and quality of data reporting at all levels.

Data review and validation meetings were held monthly or quarterly at a central location within the LGA or cluster to assess accuracy, completeness, and consistency. Pathfinder was supportive of all the data collection processes during the SMGL initiative to ensure reporting of quality and timely data. Pathfinder provided sponsorship and leadership for the data review meeting. Pathfinder also provided leadership in the areas of supportive supervision and data quality assessment. The most significant contribution in M&E came through training and mentoring provided to HF staff, and the ability to step-down these trainings. The SMGL project contributed to data quality of MNH programs in CRS.

M&E System: SMGL also contributed to the M&E system. The evaluation revealed that SMGL facilities had functioning M&E structure and capabilities. The data reporting in SMGL was linked to the national reporting system. Data collection and reporting forms were available and were used. Moreover, SMGL has indicator definitions and reporting guidelines to strengthen facility-level data collection and M&E system.

Data Analysis and Use: Analysis is done manually at the HFs and capacity for computer-based analysis is uncommon. Data is recorded on standard forms, mostly provided by the project. These are summarized in a standard reporting format and a paper copy provided to the LGA M&E person who enters the data in the DHIS 2.0 database in the LGA office. Monthly meetings that engage staff from the LGA HFs provide an opportunity to review the information. Data analysis and display were limited to dashboards and charts, which may or may not be up-to-date. In some facilities, use of data—especially when ANC and deliveries were low—resulted in some facility-oriented interventions. This includes the facilities leading community outreach programs to sensitize pregnant women to attend ANC visits and deliver in the facilities, reaching out to community, youth, and religious leaders and advocacy visits to key stakeholders.

Limitations: Consciousness about facility ownership of data is weak. Facility staff were generally weak in data analysis needed for data board and charts. Limited data use at the facilities, especially at the PHCs, resulted from weakness in data analysis and using the findings to make timely and strategic decisions to improve demand and supply sides of MNH. Unconducive HF environments—such as poor water supply, poor lighting system in some wards (including postnatal), and inadequate numbers of beds—have contributed to low demand for services in some HFs. In most instances, Pathfinder upgraded PHCs with the most demand for services, although the evaluation team did see some anomalies of very busy HFs that were not upgraded as well as at some not very busy HFs that had been upgraded.

Management, Coordination, and Convening: Interviews with government officials at all levels revealed a high degree of satisfaction with all aspects of the initiative. SMGL coordination and regular meetings with the CRS MOH and CRS PHCDA technical officials in Calabar and the LGAs were cited as a key to the effectiveness of the training, data collection, and community mobilization.

Quarterly coordination meetings between partners in CRS organized by the MOH, while highlighted by SMGL staff as indicative of close collaboration with the CRS MOH and CRS PHCDA, were viewed by the government participants as effective for coordinating activities, but less effective for transferring knowledge required for long-range planning and transition of SMGL to the CRS government. There were two areas in particular where were challenges were mentioned. One was in the design of the project. They said that they were not consulted and that they did not have the opportunity to mold the project to the needs of CRS as they perceived them based on their experience. Second, while technical staff benefited from training as master trainers and accompanied SMGL on supervision visits, CRS MOH and CRS PHCDA leaders did not feel adequately engaged in the management of the project, which they now feel will have repercussions for sustainability. Specifically, they wished they had greater knowledge and oversight over the budget, and management systems. They also regretted that they had not been consulted on decisions about which health workers should be trained. Despite these common concerns, both agencies stated that the project made very important contributions to CRS healthcare and that they wished the project were not ending.

Material Needs: Supplies, Training Support, Logistics, Incentives: SMGL, through its partners Project CURE and We Care Solar, equipped public BEmONC and CEmONC facilities with equipment, instruments, and solar lighting for the delivery room. Additionally, Pathfinder upgraded the infrastructure in high volume facilities at both levels. We Care Solar installed solar suitcases to provide overhead lighting in the delivery room and a second lamp for warming the newborn. The evaluation team found these to be functional in all facilities visited; they should be sustainable as they depend only on the sun, as long as there is no damage to wires and lighting elements. It was not clear how often lighting elements (e.g., bulbs) have to be replaced and whether they are readily available.

The equipment provided by Project CURE varied by facility. The standard equipment included a vacuum extractor, a shock garment, a scale for weighing the baby, Doppler, and an ambu bag with two sizes of masks. In other HFs, the evaluation team found donated wheelchairs, delivery beds, and handheld ultrasound scanners. The evaluation team observed that the items were all neatly stored and taken care of. There were other donated items in the facilities that were no longer functional and had been tossed aside when they no longer worked, which raised concern about what would happen in the long term if the supplies and equipment provided by SMGL were broken or lost.

Role of TBAs

Although the CRS PHCDA believed it had a commitment from SOML to continue the payments for TBAs, a new system was not in place at the time of the evaluation. The TBA incentives could have potentially adverse outcomes on continued support of TBAs for deliveries in health services. Some TBAs may revert to earlier practices to sustain their income. In communities that have passed laws that fine TBAs, it is likely they will also not refer women to the HFs when they encounter complications because of the fear of being fined. This combination of suspended stipends and punitive laws could augment maternal and neonatal deaths.

While some WDCs have come out with plans to support TBAs with incentives to continue the escorting program, this is not the case in most LGAs. The lack of a clear plan from the MOH or PHCDA raises concerns about sustaining HF births.

Government ownership

WDC: SMGL activities with the WDC, a structure that predated the project, appear to be among the most sustainable of structures for continuing the activities for which it is responsible—namely oversight and financing of the ETS and oversight and support to the PHC. Sustainability of the ETS depends on the WDC, which is responsible for raising adequate funds to supplement and replenish the funds provided by SMGL. A statement by the head of the PHC in Mkpani illustrates the importance of the WDC for sustaining changes induced by SMGL:

> *"From the onset of Pathfinder, we have a body called Ward Development Committee. Pathfinder has taught them how to sustain all these services that they have provided. We have called the WDC to the matter and [asked] them that now that Pathfinder is going, how are we going to be able to sustain this project. The committee has an account with the bank, First Bank, which at every time when we have any problem, we call the WDC that this is the problem, and they raise money for us to be able to transport a woman to the General Hospital and whatever challenges that we have during the period, which means that the WDC are here to help us sustain all services that Pathfinder has been giving to us."*

WDC members in Ikot echoed this sentiment when asked if the community is ready to take ownership of SMGL activities in the community:

> *"The WDC initially belonged to the community, and still belongs to the community. It is not a new creation, so the issue of taking ownership does not arise."*

Similarly, in PHC Ikom, the health workers said that in the case of an emergency, the CHEWs inform the chiefs who then empower the WDC to come up with a solution, such as mobilizing the ETS to take women for emergency coverage.

Nevertheless, several WDCs expressed concern about the sustainability of their activities once SMGL ends. While they are confident they can continue to support monthly meetings with refreshments, they feel less confident they will be able to pay members' and other stakeholders' transport fares to attend the monthly meetings.

Another issue came to light in asking about sustainability of WDC support for deliveries at the HFs. Many LGAs have passed local laws or ordinances that fine TBAs and families for women who do not go to the PHC or hospital to deliver. In PHC Idomi in Yakur, the WDC said that in addition to playing a role in sensitizing women and their families about the benefits of delivering in the HF, they also act "as police"—monitoring TBAs and reporting any TBA caught attending a birth at home. They refer the TBAs to the village council, which fines the TBA.

LGA: Monthly meetings initiated by Pathfinder to review data from the HFs have been taken over by the LGAs, supported by the CRS PHCDA and CRS MOH. The monthly meetings bring together representatives from all HFs in the LGA—both public and private—to provide their monthly M&E data. These meetings are likely to continue even after the end of SMGL as they now are the standard operating procedure for reporting HF data into the NDHIS 2.0 database. These meetings are also an opportunity to review the data, improve data quality, and address PHC coordination issues. The

meetings are attended by the LGA M&E officer, the M&E designee for each PHC, the LGA PHC coordinator, and M&E officers from the LGA general hospital and private hospitals in the LGA. As the quarterly cluster meetings appear to be less likely to continue, the monthly M&E meetings have also begun to include the MPDSR, which is also entered into a database. Currently there are three MPDSR platforms in Calabar (South), Ikom (Central), and Ogoja (North). Coordination at the LGA level is where the data on deaths are reviewed. The CRS MOH has already assumed responsibility from Pathfinder for funding MPDSR activities. Prior to SMGL, the HF did not routinely report MNCH data into the DHIS 2.0. The reporting on MNCH indicators is now routine.

CRS MOH/PHCDA

The two entities responsible for oversight of healthcare delivery in CRS agreed on the value of SMGL for improving the quality of healthcare services and for reducing maternal and neonatal deaths. They were not as sanguine about the transition plan, of which they said they had no knowledge. They did explain in interviews conducted by the evaluation team that they would assume responsibility for some of the components of the project. They said they were going to finance the HelloMAMA program, the Mama Kits, and try to find financing to continue incentives to TBAs, or otherwise engage them. The governor donated tricycle ambulances to each PHC, but it is the responsibility of each PHC to find a driver and to pay for fuel. In some LGAs, this responsibility has been assumed by the WDC. In others, the tricycles sit idly in front of the PHCs, while women continue to arrive at the PHC in labor on the backs of ETS motorbikes.

Both agencies appear to be relying on the World Bank program, SOML, to provide financing for most SMGL activities, including Mama Kits, HelloMAMA, and TBA stipends. There are other areas that are less clear, such as continuance of the cluster meetings, the initiative to develop a state-level harmonized M&E reporting form for use by all donors, periodic refresher training of master trainers and healthcare professionals, continuance of the mentor midwives, supportive supervision, and support and oversight of the M&E activities.

The interviews with different staff of the CRS MOH and CRS PHCDA made clear that they did not believe they had the managerial capacity to manage all parts of SMGL in an integrated and systematic fashion. Personnel shortages also threaten the sustainability of the SMGL achievements in expanding access and reducing deaths. While task-shifting to CHEWs has expanded BEmONC to 24-hour availability, it is likely that increased demand will severely overburden and tax the current workforce, especially without the oversight and on-the-job training provided by mentor midwives. For instance, the provision of LARCs may be compromised by the lack of a skilled midwife or nurse supervisor to oversee insertion of implants by CHEWs. The MOH has developed a certification process for CHEWs to have more autonomy in LARC insertion once they have passed the assessment and are certified. To qualify, they have to have been trained and had at least two supervisions. Those who qualify for certification will be supervised periodically, but will be able to insert implants without the presence of a supervisor. The great majority will likely continue to need supervisory support. Additionally, a number of stakeholders interviewed argued that CHEWs are now responsible for too many tasks, including ANC, FP, delivery, community outreach, and M&E in MNH, in addition to other health areas, such as HIV, malaria, infectious disease, child health, nutrition, and more. Staffing plans and human resource needs assessments were not part of the SMGL transition plan.

Finally, the CRS MOH and CRS PHCDA do not appear to have plans for upkeep of infrastructure, replacement of old, broken, and lost equipment, or on-site training of new staff. It is also not clear what their plan is for expansion of SMGL to additional sites as the population grows.

V. CONCLUSIONS AND RECOMMENDATIONS

SUMMARY OF CONCLUSIONS

The evidence from interviews, monitoring data, and comparison of baseline and endline data on the Health Facility Assessment supports the view expressed by virtually all the stakeholders that SMGL was a successful initiative that appeared to greatly improve access and quality of care, and reduce maternal and neonatal deaths.

The evaluation concluded that a large and complex set of interventions applied simultaneously and competently were associated with measurable and impressive improvements in health outcomes for mothers and babies in the communities with access to the HFs supported by SMGL. Pathfinder managed SMGL well, which was not an easy task, given the complexity of the endeavor, the multiple actors involved in implementation, and the large and varied number of stakeholders.

The major challenge is how well the SMGL model can be implemented by the CRS government health agencies, as the level of integration and oversight provided by PF will be challenging to continue. The endline Health Facility Assessment echoes this concern:

> *"Sustaining the gains achieved by the initiative will require commitment from stakeholders at the state and local government levels. Concerted effort should be made to institutionalize the strategies of the SMGL Initiative for a strengthened health system. It is also necessary that various learnings are available from the program, along with several innovations that should be strengthened."* (SMGL, June 2019, p. 8)

Discussions with the CRS MOH and CRS PHCDA raised concerns about the availability of sufficient resources and how they may be used. While the technical staff of both agencies has been intimately involved as master trainers and as supportive supervisors, there has not been a parallel set of actors from the CRS health sector engaged in the day-to-day management of SMGL. This issue was highlighted by the leadership of both agencies. Additionally, both the SMGL transition plan and the CRS government's focus for the future have been on discrete highly visible components of the project, some of which are key to sustainability, such as the ETS, continued mentorship at the CEmONC level by resident doctors from the teaching hospital, WDC oversight of HF, and LGA monthly data meetings. Others, such as a lack of commitment to continue the mentor midwives program, doubts about continuance of cluster meetings, and a lack of plans for maintenance and upkeep of facilities and equipment are likely to threaten the quality of services. The CRS government has committed in the short term to provide what the evaluation team concluded were unsustainable components, such as the Mama Kits, stipends for TBAs, and HelloMAMA messaging. The last two have not yet been funded.

A major consideration for USAID, moving forward, is to reconsider at this point its decision to end funding without sufficient time and mentoring for a smooth and sustainable transition. It would also be useful to have more population-based data on CRS to understand the full effect of the program, as was done in the other two SMGL countries. It is evident that the model is effective—i.e., the concept has been proven. The questions are whether it can be implemented at scale by local and state governments, and if donors are willing to invest in a longer-term process in support of scale-up and sustainability.

The major lessons learned from SMGL are:

- It is possible to reduce MMR and NMR within a short period of time with adequate resources and skilled staff, but the results should not be assumed to be sustainable within a short-time horizon.
- Reducing MMR and NMR requires a health systems approach with integrated and interconnected interventions from the household to the MOH policy level.
- The model requires highly experienced and competent management, with multiple layers of supportive supervision, training, mentorship, and sustainable financing mechanisms.
- The model is costly and labor-intensive, and therefore requires adequate levels of financing and long implementation horizons to be sustainable.

The conclusions and recommendations that follow are more specific to the different components of SMGL.

CONCLUSIONS BY EVALUATION QUESTION

Changes in access and utilization of MNRH services

A combination of strengthening the WDC, creating ETS, and engaging multiple stakeholders in community outreach appeared to stimulate increased demand for health services. These efforts resulted in improved birth preparedness, perception of improved care, and recognition of danger signs, which stimulated increased use of the health services. The factors likely to sustain these achievements include sustainable ETS (in LGAs where WDCs have come up with funding schemes), outreach by the CHEWs to pregnant women and other community stakeholders, some TBAs committed to escorting women with or without a stipend, and WDCs actively engaged in continued outreach.

Several factors may dampen continued increases and improvements. These include lack of continued incentives to TBAs and pregnant women to deliver in HFs and churches that continue to induce their parishioners to deliver at the church. Decreased quality of care may also be due to a demand that overtaxes the existing human health resources, so that they limit time on outreach and education activities, and experience stress that has negative repercussions on how they interact with clients. Quality of care may also be affected by transfer of qualified SMGL-trained health workers to non-BEmONC PHCs, and rotation of trained CEmONC healthcare providers to other departments in their hospitals. This is especially risky if there is not a continued emphasis on step-down training and refresher courses. As a result, potential users of the health services may once again perceive these services as unfriendly and not responsive to their needs.

Quality of MNRH services

The expansion to 108 facilities, that each qualify as either BEmONC or CEmONC, is one of the great achievements of the project. Prior to SMGL, there were no BEmONC facilities and only one CEmONC that met the WHO criteria for appropriate signal functions in the entire CRS. Yet, it is also important to highlight that not all the PHCs and CEmONC facilities supported by SMGL strictly meet the classification of CEmONC today, though the capability to perform the signal functions (all of them) is a necessary prerequisite to reduce maternal and neonatal deaths from direct obstetric and neonatal causes.

It remains unclear whether SMGL efforts to reduce maternal and neonatal mortality have reached the desired level of impact, and what further efforts targeting maternal and neonatal survival are needed as measurements of reductions in deaths have only been measured at the facility level. As deaths in

communities tend to be underreported, it is not possible to measure the effect of SMGL on reductions in MMR and NMR.[22] The baseline and endline studies conducted by Pathfinder in 198 of the 108 SMGL facilities did show remarkable reductions in MMR (66 percent) and NMR (47 percent) in CRS HF. Unless all births take place in HFs, it is not possible to extrapolate from facility data to understand trends in the population as a whole. Nevertheless, the results produced by the project are impressive and worth paying attention to.

As evidenced by the monitoring data and interviews, the evaluation team concluded that having provided high quality trainings, appropriate to different types of healthcare providers, SMGL was able to increase access, utilization, and level of care in the targeted HFs in CRS. The capacity-building strategy was beneficial, particularly for the CHEWs. Technical trainings were critical, and the ENC training was pivotal in changing newborn outcomes. The trainings allowed for CHEWs to acquire higher-level skills essential to intervening properly or realizing when the needs of a client are beyond their capacity and should be referred. Prior to SMGL, CHEWs' basic skills were not adequate, nor was their knowledge of danger signs and when it was the right time to refer. SMGL created a support system through supportive supervision by nurses and midwives, and the onsite presence of well-trained mentor midwives that permitted them to perform above the level at which they had originally been trained.

The mentorship scheme contributed to creating better and more skilled health providers, which are today able to recognize and manage the majority of the obstetric and neonatal complications. However, the sustainability of deploying retired midwives and consultants is somehow compromised without financial support. If this important support system is removed, as may happen, it will have major consequences for quality of care in labor and delivery, and potentially will threaten the delivery of LARC FP methods. Although trained to insert implants, CHEWs must be supervised by a trained midwife or nurse during insertion, unless certified. Similarly, IUDs are likely to be less available, as mentor midwives were responsible for insertion, and CHEWs are not allowed to insert IUDs.

Other challenges also remain, particularly in the provision of postnatal follow-ups and water supply. SMGL has in some ways undervalued both activities that have strong links with maternal deaths caused by postpartum infections.

Through the investment of SMGL in the delivery of a comprehensive and evidence-based package of RMNH interventions, it is clear that behavior change, in both health system users and providers, requires implementing agencies to venture down a long process that starts at the community level and ends at the decision-making level.

Contributing to the reduction of maternal and newborn mortality requires huge logistics and monetary efforts and a real involvement and ownership of the recipient health system. And this takes time. Nevertheless, the evaluation attributes to Pathfinder the good *modus operandi* of the SMGL project and, particularly, the operational challenges in the rural areas of CRS. Pathfinder was able to engage deeply with the health system and this was life-changing for pregnant women and newborns in CRS.

[22] MMR is the measure of the number of maternal deaths during pregnancy through 40 days postpartum from direct obstetric causes for every 100,000 live births. For more on the complications of MMR measurement see Magawadere, Kana, and Van den Broeke, 2017.

Community contributions to changes in access and utilization of MNRH services

SMGL has facilitated a combination of innovative and proven strategies at the community level, that are among the activities most likely to be sustainable, as they are grounded in existing local organizations and actors. In particular, the engagement and capacity building of the WDC was key to effective coordination of many activities at the community level, especially the coordination and sensitization of community actors in driving increased demand, access, and utilization of HFs by pregnant women for ANC, FP, and labor and delivery. The activities were less successful in raising awareness about the importance of PPC.

The engagement and behavioral transformation of the TBAs, who now have greater knowledge of the danger signs and when to refer women to the HF for quality healthcare, also increased utilization of ANC and delivery services. The coordination of the ETS by the WDC and increased collaboration between WDCs, VCs, TBAs, RLs, and PHC staff were also a huge success in many communities.

However, several issues emerged that may have consequential impact on the sustainability of the community-level interventions, particularly the TBAs engaged by SMGL in CRS refusing to accept home-based-deliveries and instead escorting women to the HF. By providing a combination of incentives and training, SMGL was able to convince some TBAs in the communities around the SMGL HFs to change their practices. Investments in alternative livelihood options instead of in stipends might have been a more sustainable option for discouraging home births. The churches also remained a major competitor for the health services on delivery care and SMGL was less successful in most communities in discouraging church-based births.

It is difficult to assess whether that has had any effect beyond those target areas. For instance, Ogoja LGA has a total of 49 PHCs. SMGL worked, and evidently engaged, TBAs within three of them. It is therefore not clear whether other TBAs outside SMGL-domiciled areas in Ogoja may have learned from the few within SMGL locations. Second, a situation depicting duplication of activities was observed between the WDCs, VCs, and TBAs on the one hand and CBOs SMGL engaged in outreach activities on the other. Everyone had different competing incentives (e.g., payment, better indicators, more ANC registration fees) to bring women into the HF.

Most of the TBAs decried activities of the PPMVs as they reportedly have assumed traditional roles of TBAs while undertaking traditional ANC, and in some cases attending deliveries. The implication as reported by a majority of the TBAs is life-threatening and in some cases actually leads to death. Unfortunately, TBAs reported to have consistently been blamed, whereas little or no blame was given to the PPMVs. SMGL, however, paid little attention to these issues and no evidence was provided to indicate whether SMGL did engage PPMVs and to what extent. There was no clear-cut evidence to show how the WDC members can sustainably fund their meetings, except funding for supporting ETS activities—although this varies across communities. There was no evidence among TBAs that their activities would be sustained upon the exit of SMGL.

Gender

Mainstreaming gender into the project was not a priority, as the project and USAID did not focus attention adequately on the issue and sufficient resources were not allocated. By depending on expertise from headquarters, the project also did not receive the support that was anticipated.

There was an attempt to integrate gender into trainings for CBOs and health workers. These trainings were based on the FMOH modules, which were quite theoretical and not adapted to the local context.

It was difficult to document changes in outcomes related to gender equality as there were no indicators that measured outcomes from either the FTP activities or from the training. Reporting on gender-related activities consisted of a standard paragraph in the quarterly reports with virtually identical wording from one quarter to the next. When queried about gender knowledge and application of training, many healthcare providers gave inappropriate answers, especially related to gender-based violence, that potentially may endanger women seeking help at the HF.

Based on responses in group interviews conducted by the evaluation team, there were indicators of increased awareness among men that they also have an important role in the care of their newborn babies. Men also became more supportive of women's use of ANC and delivery services at the HF. While this is a positive change in terms of improving health outcomes, it was not indicative of changes in gender relations, as men continue to be the decision-makers. They have just changed their decisions, rather than sharing the decision with their pregnant partners. It was not clear which strategy was responsible for those changes. Leveraging the gains of the FTP program appeared to be a good strategy but it was restricted to a very small number of communities. SMGL was effective at communicating health messages to a broad array of stakeholders, including men, and key decision-makers and authorities in the communities surrounding SMGL HFs. Greater attention to addressing power imbalances in decision-making between men and women would have given women more agency over their own healthcare decisions.

A focus on PPFP beginning in ANC, after birth, and PPC for the mother and baby, with an emphasis on spacing, increased women's access to contraceptives, but it was a lost opportunity for addressing other gender-based constraints to women having a say over whether they would accept FP. ANC was a lost opportunity to engage men on the value of FP to women's health and potentially to their household's economic status. Some women did act on their own, even when their partners were opposed to it, by seeking out FP methods that could be hidden from their partner. Many women could not act on their desire for FP without their partner's consent as they lacked control over the financial resources to access care.[23] Some men were persuaded that FP was beneficial and decided to support their partners. A few couples stated that one side benefit was greater fidelity of men in the marriage, because both partners had less fear of pregnancy, making sexual relations among partners more frequent.

The huge increase in the number of women accessing ANC and delivering in the facility can easily be associated with the sensitization by WDCs or health workers as well as incentives given. The link to it being a change in attitude by the women and men is still an open question.

On a broader scale, based on interviews with project M&E staff and the Devtech Systems M&E activity, the evaluation team concluded that there are no gender indicators for any USAID health projects except a new sexual violence project. While SMGL followed ADS 201 requirements to sex-disaggregate pertinent indicators, they did no analysis of what the data indicated in terms of gaps or inequalities. Guidance provided by both ADS 201 and 205 clearly states that sex-disaggregation of indicators does not signify sufficient attention to measuring gender inequalities in USAID-funded activities.

Sustainability and ownership

While sustainability was not an explicit objective of the project, SMGL has led a number of local structures that demonstrate good prospects for sustainably supporting utilization of MNCH services and reducing delays 1 and 2. If the CRS MOH and CRS PHCDA can continue to provide opportunities for

[23] Contraceptives are provided for free, but there are financial and opportunity costs associated with accessing care.

refresher training, address human resource shortages, and support the continuance of mentorship programs, three-delay dimensions of the SMGL model will also be sustained.

SMGL's plan is a closeout plan, not really a transition plan. It does not adequately address managerial and resource needs of the CRS government to continue the three-delay SMGL model, even just within the current project areas. Although the CRS MOH expects that the SOML program will invest significant resources into CRS to continue much of SMGL, SOML ends at the end of 2019 according to the World Bank website. The SMGL closeout plan lists 33 activities implemented by the current project.

There are still many questions about how the transition will be implemented and to what extent the CRS government has the capacity to sustain the integrated SMGL model. The next two months is not adequate time to ensure a sustainable transition.

The lack of inclusion of the CRS MOH and CRS PHCDA in the initial design and management of SMGL, and the lack of more vigorous support to make a sustainable transition is not consistent with USAID's Self-Reliance Strategy.

RECOMMENDATIONS

Changes in access and utilization of MNRH services and quality of MNRH services

- The HF should include TBAs in their monthly meetings/activities to continue their involvement and sensitization, and to highlight their importance as part of the wellness of the communities. Part of the revenues from the HF's cost recovery could be used as a "token" for the TBAs. Alternatively, the system SMGL has supported to sustain the ETS could also be applied to the TBAs.

- Receiving delivery kits (Mama Kits) has proved to be important for pregnant women and has increased the utilization of the HF. However, without allocated funds, the delivery of birth kits is unlikely to be sustainable. Instead it is advisable to strengthen support for birth preparedness. Assisting women, their partners, and families to be adequately prepared for childbirth by making plans on how to respond if complications or unexpected adverse events occur, birth preparedness is a much more effective way to educate women before the delivery and should be reinforced all along the pregnancy, during ANC visits and in community sensitizations.

- The health providers could help the women with a pictorial birth-planning card in which a "purchase calendar" lists the items to be acquired in preparation for the birth. During outreach activities and ANC visits, the health workers would check the completeness of the card.

- Another way to help women with birth preparedness is by promoting savings or income generation for small emergency funds at the family level.[24] To be effective, birth preparedness needs the involvement of men and the promotion of behaviors supportive of women's decision-making or joint decision-making.

- The transition plan should include resources for refresh trainings and supportive supervision as needed to maintain the health workers' skills in low-volume delivery facilities; a policy on human

[24] World Health Organization, "Birth and Emergency Preparedness in Antenatal Care," accessed 26 November 2019. https://www.who.int/reproductivehealth/publications/maternal_perinatal_health/emergency_preparedness_antenatal_care.pdf.

resources retention would play an important factor in a facility with a high turnover of institutional deliveries.

- The partograph is an effective tool to prevent prolonged labor, reduce operative intervention, and improve neonatal outcomes. Emphasis on its use for all births should continue. Since completing the partograph is a time-consuming procedure, it is affected by time constraints suffered by overburdened staff. Therefore, appropriate staffing levels are needed to get full benefit out of the partograph. In high-volume facilities with an inadequate number of staff, the completion of the partograph could be challenging unless the number of health workers is increased.

- Greater attention should be paid at the postpartum period. TBAs could play a role to monitor both women (i.e., signs of postpartum infections) and her newborn during the first weeks after birth. Expanding home visits, outreach activities, and sensitization messages starting from ANC visits should be an asset in any program targeting the reduction of maternal deaths.

- Ensuring safe water systems, at least in maternity wards and delivery rooms (water tanks and provision of piped water) should be contemplated in projects that invest in infrastructure renovations. A sustainable source of electricity is also needed for lighting and proper refrigeration of oxytocin and other drugs requiring a cold chain.

Community contributions to changes in access and utilization of MNRH services

- Future interventions should look at exploring synergy with existing state initiatives for possible integration of community actors—particularly WDCs—as a way of making them economically viable to sustain their activities of promoting increased demand for, access to, and utilization of quality healthcare services on MNCH.

- Future interventions should support facilitation of equal spread and distribution of the tricycle ambulance across all PHCs. Here, CRS MOH should also be made to provide permanent drivers within each of the HF. CRS MOH observably has evolved with a complementary strategy for sustaining the ETS initiative by provision of "tricycle ambulance" to PHCs across CRS, although not in all PHCs. This helps to effectively respond to the delay in getting women in labor or complication to the HFs.

- While it is commendable that SMGL had worked with TBAs across the 18 LGAs in CRS, working within fewer LGAs would have been effective and sustainable. If the project had worked in fewer LGAs, it would have been able to capture more TBAs whose behavioral transformation can be contagious enough to ensure the desired change. This also applies to other community-rooted initiatives. Given the challenges of integrating community and health system focused activities, future interventions would benefit from starting with fewer LGAs, developing effective models, and then scaling up to other LGAs to maximize project outcomes.

- A future intervention should consider long-term income-generating activities initiatives for TBAs engaged on future programs. The majority of the TBAs on the SMGL intervention who have expressed worries on sustainable means of livelihood have not agreed to stop accepting deliveries as TBAs, but instead to support increased demand for, access to, and utilization of HFs by pregnant women in the communities. However, the inability to secure an alternative income-generating activity may have negative implications.

- The illegal activities of PPMVs were reported by the TBAs as sabotaging efforts of the TBAs in promoting increased demand for, access to, and utilization of HFs for quality healthcare. Future interventions should engage with PPMVs to a greater extent, perhaps including them in some of the private sector initiatives that benefited private clinics and hospitals. PPMVs could more productively play a role in also referring women to the HFs who seek their advice and remedies. They might also be enlisted for community distribution of contraceptives such as condoms and pills.

Gender

- Mainstreaming gender into the project should start at the design stage with specific gender baseline data collated and a gender strategy developed as an integral part of the project including the development of gender indicators. MNCH projects require gender integration in the project MEL plan just like other types of activities. In the future, project MEL plans for health projects should include reporting on qualitative and quantitative indicators for outputs and outcomes that measure changes in gender roles and norms (beliefs and practices), and access and control over assets and information, norms, and relations of power. A clear example is a project called Youth Leadership Entrepreneurship Access and Development (YouLead) that was implemented by Cuso International, Nigeria, with funding from Global Affairs Canada. A gender strategy was developed at the design stage with goals and objectives and a reporting mechanism was developed from the strategy for tracking by the M&E team.[25]

- In the future, the gender position should not be the position cut from the project to save money as gender integration is required in all USAID projects. Rather, resources for gender integration should be fully allocated, especially when gender-based constraints are identified as a key barrier to delays 1, 2, and 3. The idea of allocation of the right resources—human and financial—to gender-related components and projects cannot be overemphasized. Funds should be allocated for hiring a gender specialist or a program officer with some gender expertise and the appropriate amount of level-of-effort to do his or her job.

- Gender training should be more practical and hands-on for both project implementers and healthcare providers. It should also be adapted to local contexts as gender relations are not identical across different contexts. For instance, all examples in the training curriculum should be based on gender relations in different rural ethnic groups within the project area.

- When projects like FTP are concluded, there should be a way to gather key data elements for future programing. A qualitative or quantitative baseline and endline is needed to document changes in beliefs and practices related to men's and women's roles and decision-making.

Sustainability

- If there are expectations that an integrated model like SMGL will be transitioned in its entirety to local and state governments, it is recommended that those stakeholders and decision-makers are involved from the design stage and have a continuing role in management throughout the project. That can be accomplished in a number of ways, including naming government counterparts to senior leadership on the project. Similar pairing is recommended for technical staff. Over time, the onus of leadership and management can gradually shift from project

[25] The evaluators are happy to provide USAID/Nigeria with examples.

personnel to government counterparts. An alternative approach would be to begin joint transition planning from the first day of the project with delineation of a series of transition benchmarks for which responsibility would move from the implementing partner to the government at strategic points up to a final year where the government assumes responsibility for the implementation and the implementing partner is available as an advisor.

- Incentive structures should be well thought out, analyzed carefully for adverse consequences, and used only temporarily with the idea of transitioning them to more sustainable solutions during project implementation, not at the end. This will allow implementing partners to problem-solve and fine-tune solutions that do not work effectively. For instance, if SMGL had used escorting stipends as a short-term measure to capitalizing alternative businesses or training for TBAs, the ending of the stipends would not have been so abrupt and potentially threatening to a major accomplishment of the project.
- USAID and other donors should learn from the SMGL experience, as well as other successful efforts to reduce MMR and NMR. The major lessons are:
    - It is possible to reduce MMR and NMR within a short period of time with adequate resources and skilled staff but the results should not be assumed to be sustainable within a short-time horizon.
    - Reducing MMR and NMR requires a health systems approach with integrated and interconnected interventions from the household to the MOH policy level.
    - The model requires highly experienced and competent management, with multiple layers of supportive supervision, training, mentorship, and sustainable financing mechanisms.
    - The model is costly and labor-intensive, and therefore requires adequate levels of financing and long implementation horizons to be sustainable.

The recommendation is to make a commitment to:

- Envision a longer time horizon and higher resource requirements than are necessary for other health interventions, such as FP or child health, that don't require costly health interventions like surgery and blood transfusion, or transport services.
- Eliminate the unpredictable, time-consuming, and sometimes challenging process of building local and state ownership and do it in a way that all involved feel like equal partners.
- Invest in measuring outcomes at the individual and group (e.g., gender), facility, and population levels to better understand the dynamics of change and what factors contribute to changes in outcomes. Include resources for data collection, analysis, and group learning.
- Invest only in training that is supported by hands-on mentoring and supportive supervision, with mechanisms for refreshing and updating skills of previously trained health workers and transferring skills to new health workers.
- Establishing a digital environment to encourage data use for decision-making. Make greater use of tablets for data collection and analysis, and increased use of mobile technology for communication between healthcare providers and clients, and among healthcare providers at different levels of the health system.

ANNEX I. SCOPE OF WORK

Assignment #: 669 [*assigned by GH Pro*]

Global Health Program Cycle Improvement Project (GH Pro)
Contract No. AID-OAA-C-14-00067

EVALUATION OR ANALYTIC ACTIVITY STATEMENT OF WORK (SOW)
Date of Submission: 10-09-18
Last update: 8-26-19
Amendment #1

I. TITLE: Nigeria Saving Mothers Giving Life (SMGL) End of Project Evaluation

II. Requester / Client

■ USAID Country or Regional Mission
Mission/Division: HPN / Nigeria

III. Funding Account Source(s): (Click on box(es) to indicate source of payment for this assignment)

☐ 3.1.1 HIV	☐ 3.1.4 PIOET	■ 3.1.7 FP/RH
☐ 3.1.2 TB	☐ 3.1.5 Other public health threats	☐ 3.1.8 WSSH
☐ 3.1.3 Malaria	■ 3.1.6 MCH	☐ 3.1.9 Nutrition
		■ 3.2.0 Other (specify): Health

IV. Cost Estimate: Note: GH Pro will provide a cost estimate based on this SOW

V. Performance Period

Expected Start Date (on or about): February 2019
Anticipated End Date (on or about): November 1, 2019

VI. Location(s) of Assignment: (Indicate where work will be performed)

Nigeria: Abuja and Cross River State

VII. Type of Analytic Activity (Check the box to indicate the type of analytic activity)

EVALUATION:

■ **Performance Evaluation** (Check timing of data collection)
☐ Midterm ■ Endline ☐ Other (specify):

Performance evaluations encompass a broad range of evaluation methods. They often incorporate before–after comparisons but generally lack a rigorously defined counterfactual. Performance evaluations may address descriptive, normative, and/or cause-and-effect questions. They may focus on what a particular project or program has achieved (at any point during or after implementation); how it was implemented; how it was perceived and valued; and other questions that are pertinent to design, management, and operational decision making

■ **Impact Evaluation** (*Check timing(s) of data collection*)

☐ Baseline ☐ Midterm ☐ Endline ☐ Other (specify):

Impact evaluations measure the change in a development outcome that is attributable to a defined intervention. They are based on models of cause and effect and require a credible and rigorously defined counterfactual to control for factors other than the intervention that might account for the observed change. Impact evaluations in which comparisons are made between beneficiaries that are randomly assigned to either a treatment or a control group provide the strongest evidence of a relationship between the intervention under study and the outcome measured.

OTHER ANALYTIC ACTIVITIES

☐ **Assessment**

Assessments are designed to examine country and/or sector context to inform project design, or as an informal review of projects.

☐ **Costing and/or Economic Analysis**

Costing and Economic Analysis can identify, measure, value and cost an intervention or program. It can be an assessment or evaluation, with or without a comparative intervention/program.

☐ **Other Analytic Activity** (Specify)

PEPFAR EVALUATIONS *(PEPFAR Evaluation Standards of Practice 2014)*

Note: If PEPFA-funded, check the box for type of evaluation

☐ **Process Evaluation** *(Check timing of data collection)*

☐ Midterm ☐ Endline ☐ Other (specify): _____

Process Evaluation focuses on program or intervention implementation, including, but not limited to access to services, whether services reach the intended population, how services are delivered, client satisfaction and perceptions about needs and services, management practices. In addition, a process evaluation might provide an understanding of cultural, socio-political, legal, and economic context that affect implementation of the program or intervention. For example: Are activities delivered as intended, and are the right participants being reached? (PEPFAR Evaluation Standards of Practice 2014)

☐ **Outcome Evaluation**

Outcome Evaluation determines if and by how much, intervention activities or services achieved their intended outcomes. It focuses on outputs and outcomes (including unintended effects) to judge program effectiveness, but may also assess program process to understand how outcomes are produced. It is possible to use statistical techniques in some instances when control or comparison groups are not available (e.g., for the evaluation of a national program). Example of question asked: To what extent are desired changes occurring due to the program, and who is benefiting? (PEPFAR Evaluation Standards of Practice 2014)

☐ **Impact Evaluation** *(Check timing(s) of data collection)*

☐ Baseline ☐ Midterm ☐ Endline ☐ Other (specify): .

Impact evaluations measure the change in an outcome that is attributable to a defined intervention by comparing actual impact to what would have happened in the absence of the intervention (the counterfactual scenario). IEs are based on models of cause and effect and require a rigorously defined counterfactual to control for factors other than the intervention that might account for the observed change. There are a range of accepted approaches to applying a counterfactual analysis, though IEs in which comparisons are made between beneficiaries that are randomly assigned to either an intervention or a control group provide the strongest evidence of a relationship between the intervention under study and the outcome measured to demonstrate impact.

☐ **Economic Evaluation** (PEPFAR)

Economic Evaluations identifies, measures, values and compares the costs and outcomes of alternative interventions. Economic evaluation is a systematic and transparent framework for assessing efficiency focusing on the economic costs and outcomes of alternative programs or interventions. This framework is based on a comparative analysis of both the costs (resources consumed) and outcomes (health, clinical, economic) of programs or interventions. Main types of economic evaluation are cost-minimization analysis (CMA), cost-effectiveness analysis (CEA), cost-benefit analysis (CBA) and cost-utility analysis (CUA). Example of question asked: What is the cost-effectiveness of this intervention in improving patient outcomes as compared to other treatment models?

VIII. BACKGROUND

If an evaluation, Project/Program being evaluated:

Activity Name	Saving Mothers Giving Life (SMGL)
Project Name	Evidence to Action (E2A)
Implementer	Pathfinder International
Cooperative Agreement #	AID-OAA-A-11-00024
Total Estimated Ceiling of the Evaluated Project/Activity (TEC)	$3,500,000 per annum
Life of SMGL Activity	September 2014 to September 30, 2019
Active Geographic Regions	Cross River, Nigeria

Background of project/program/intervention (*Provide a brief background on the country and/or sector context; specific problem or opportunity the intervention addresses; and the development hypothesis*)

The USAID Saving Mothers Giving Life (SMGL) program is a 5-year, centrally managed activity, implemented in Nigeria under the E2A cooperative agreement with a $16 million ceiling, under award number AID-OAA-A-11-00024. The program awardee is Pathfinder International.

The *goal* of SMGL is to accelerate reductions in maternal and neonatal morbidity and mortality in Cross River State (reduce maternal mortality ratio by 25% and neonatal mortality rate by 35% in Cross River state by 2019). USAID Nigeria selected the Saving Mothers Giving Life (SMGL) program to support the following activity objectives;

- Increase timely utilization of institutional delivery and FP services by reducing social, economic and geographic barriers to care seeking.
- Improve the quality of maternity care, institutional delivery services-including emergency obstetric and newborn care & FP services.
- Ensure women and their newborns are provided key health services in an integrated manner including the use of life-saving innovations and FP services; improving linkages and referrals between private and public-sector providers using a total market approach.
- Strengthen the capacity of health system to capture, evaluate, and report on birth outcome s using community and facility health information systems and advocate for more state resources for sustainable FP/RH and AYSRH programs.

Achieving SMGL's goal is dependent on achieving several intermediate results (IR) and sub-IRs as represented in the Results Framework (p.8). The activities under the intermediate results contribute to increasing coverage and quality of maternal, newborn, and reproductive health services in public and faith-based facilities; strengthening existing health systems by addressing delays in seeking appropriate care, in reaching care, and in receiving timely, quality care, and supporting the Cross-River State government and relevant stakeholders to consolidate their plans and strategies for sustainability.

The **ten** SMGL result areas are:

1. **Increased access to institutional delivery services in healthcare facilities**. Knowledge about services, cultural barriers like myths, economic barriers like poverty, and physical barriers like poor road network amongst others pose as barriers to accessibility of essential maternal and newborn facility-based services in Cross-Rivers state. To ensure that pregnant women within the state are able to have timely access to quality maternal and newborn health services, including emergency care in the event of complications, SMGL through counterpart funding supports the implementation emergency transport services (ETS) to the Ward Health Development Committees (WHDC) in the wards hosting supported facilities. SMGL builds the capacity and strengthens existing WHDC to engage community stakeholders (religious leaders, men and women groups and local government chairman) and local

transportation union in printing of ETS vouchers, increasing the database of emergency volunteer drivers, continuous orientation and reorientation of volunteer drivers on the operationalization of ETS, raising local funds for the smooth running of ETS services through household/village contributions at regular interval, donations from community philanthropist and social groups, ascribing a certain percentage of the WHDC IGR to ETS and selling of ETS vouchers to pregnant women at subsidized rate and routine audits of WHDC account.

2. **Increased demand for and utilization of institutional delivery and FP/MNH services at all levels**
   To improve the awareness and knowledge of the populace of Cross River State on the availability of quality RMNCH services, the merits of skilled birth attendance for all deliveries and the important role family planning plays in population health, SMGL initiative leverages on existing quarterly town hall meetings by SPHCDA to reach key community stakeholders on uptake of integrated RMNCH services, incorporating RMNCH messages into every outreach service and ensuring further improvement in uptake of institutional delivery services.

3. **Improved identification, follow up, and support of pregnant women, mothers and their newborns**
   SMGL program strengthens the capacity of facility staff to generate monthly ANC missed appointments list for tracking clients and linking them back to the health facility, leveraging the already existing practice of posted college of health technology and school of nursing/midwifery students and N-Power beneficiaries to carry out home visits to these women thereby reducing booked cases getting lost to follow up from the health facilities.

4. **Improved capacity of health facilities to deliver round the clock quality MNH - including EmONC and FP services**
   To ensure the continued availability of capable HRH in the state and in supported facilities, the SMGL project provides joint supportive supervision and mentorship of the health workforce on RMNCH services, including follow up mentorship for facilities whose staff have been trained on LARCs. To complement this supportive supervision and mentorship, particularly in comprehensive health facilities that have higher volume of patronage for MNH services in the state, the project supports the deployment of retired midwives as on-the-job mentors for healthcare providers in these EmONC sites, while also providing continued support for improved quality of documentation and service through deployed facility support staff in the EmONC facilities.

5. **Improved capacity of service providers to use evidence-based life-saving innovations**
   The SMGL project contributes to improving the capacity of health facility providers to deliver services through increased knowledge and resources at all levels of the health system. The project conducts a refresher orientation for core LGA-level ISS team of M&E, PHCCs, FP supervisors and CRSMoH on MNH/FP to transition/institutionalize ISS. This ensures continued and effective utilization of MNH & /FP innovations and promotion of best practices. The project builds the capacity of mentors comprising established core LGA-level ISS teams, PHCDA, SOGON/NISONM and SMOH on the use of the mentorship app - a digital mentorship application which is an mhealth innovation that is designed to aid mentors in mentoring processes for key MNH/FP services and procedures using WHO standards. It helps mentors to provide technical support and mentoring to supported facilities using an electronic MNH/FP checklist as a guide. The application auto-generates feedback for service providers and an action plan to strengthen health systems and quality of care processes.

6. **Improved capacity of service providers to reach women of reproductive age with strategies in key areas of maternal, newborn, and family planning services**
   The project conducts mentor midwife-led service delivery outreaches in conjunction with facility staff to sustain increase in facility uptake of MNH/FP services. The outreaches provide integrated FP/MNH services and involve key influencers such as religious leaders and women leaders, with the aim to reach 7,000 additional pregnant women and WRA with services.

7. **Improved referral systems to ensure access to needed MNH and EmONC services**
   To ensure timely referrals, strengthen linkages between facilities for MNH/RH/FP services and prompt treatment of pregnant women and newborns in private and public facilities, the SMGL project supports monthly cluster coordination/referral meetings and transition these meetings by integrating them with the monthly Local Government Heads of Unit meetings. In addition, having mapped and orientated traditional birth attendants in the state on danger signs and the need to make prompt referrals, the project worked out a transition plan for the TBAs to become birth escorts and facility-based birth companions leveraging similar state government plans with SOML.

8. **Increased availability of skilled healthcare providers**
   To address the dearth of skilled birth attendants, and human resources for health in general, the SMGL works to sustain its fruitful partnership with SOGON and NISONM to provide technical support/mentorship to strategic facilities with high volumes and high numbers of complicated cases.

9. **Improved state level coordination capacity of integrated health program management**
   To ensure the continued availability of capable HRH in the state and in supported facilities, SMGL works to provide joint supportive supervision and mentorship of the health workforce on RMNCH services. This joint supportive supervision will serve to build the capacity of officers of the SMOH and CRSPHCDA to sustain good quality of care across all facilities by being able to provide quality mentorship and supportive supervision.

10. **Increased state capacity of systems to capture, evaluate and report on birth outcomes**
    With the successful establishment of MPDSR in Cross River state and at the health facility level, SMGL project works to strengthen the existing maternal and perinatal deaths surveillance response (MPDSR) committee in the state through continued facilitation of quarterly meetings to institutionalize a systematic approach towards the identification, reporting and review of maternal and perinatal deaths.

The ten intermediate results of SMGL work in synergy to deliver the intended program outcome. The first-three results aim at increasing timely utilization of institutional delivery and FP services; the fourth and fifth results to improve the quality of maternity care, institutional delivery services and FP services; sixth to eight results ensure that women and their newborns are provided key health services in an integrated manner; and the ninth and tenth results seek to strengthen the capacity of health system to capture, evaluate, and report on birth outcomes.

Summary of SMGL/Nigeria Interventions

IR 1: Activities

Utilization of institutional delivery services increased: SMGL procured and distributed MAMA kits to supported sites for eventual distribution to expectant mothers. SMGL facilitated bi-annual town hall

meetings with key community stakeholders on uptake of integrated RMNCH services. SMGL conducted home visits to identify pregnant women, encouraged ANC attendance and delivery in health facility.

IR 2: Activities
The quality of maternal and newborn care improved: SMGL supported the FMOH to conduct a stakeholder meeting to develop National Operational/Implementation guide on KMC. SMGL facilitated monthly facility staff meetings to review service delivery and performance. SMGL conducted orientation for mentors and PHC coordinators on evidence-based MNH and FP interventions. The use of bubble continuous positive airway pressure (bCPAP) for airway support in 3 selected CEmONC facilities increased.

IR 3: Activities
SMGL procured and distributed FP/RH related job aids, guidelines, SOPs and IEC materials to supported facilities and CBOs. SMGL works to address delays in reaching health facilities through scale-up of emergency transport system to additional wards hosting supported facilities (14 CEmONC wards and 23 BEmONC wards) Conduct non-residential training for additional 385 TBAs on identification of danger signs in pregnancy and prompt referrals as part of strategies to increase institutional deliveries.

IR4: Activities
Facility Health Information/logistic Systems Strengthened: SMGL strengthens capacity of health facilities to document health outcomes through trainings and quarterly joint integrated supportive supervision with MDAs and CRSG, and strengthens commodity logistics systems by providing logistic support to strengthen FP TWG meetings through regular quarterly meetings. SMGL conducted non-residential FP CLMIS Training for CHEWs.

Theory of Change of target project/program/intervention

Description of the Problem, Development Hypothesis(es), and/or Theory of Change
Problem Statement
Despite continuous efforts to improve maternal, neonatal and child health (MNCH) outcomes in Nigeria, some relevant MNCH indicators remain poor. According to the Nigeria Demographic Health Survey (2013), the maternal mortality ratio (MMR) for the country is 576 per 100,000 live births and the neonatal mortality rate (NMR) is reported as 37 per 1,000 live births. In the South-South region of the country, where Cross River State (CRS) is located, the NMR is 32 deaths per 1,000 live births. CRS has a fertility rate of 5.4, a modern CPR of 24-percent, and an unmet need for FP of 31 percent. While a reasonably high percent (73%) of pregnant women in the state receive ANC from a skilled provider, only about 40 percent deliveries are attended to by a skilled provider. Reasons for not delivering in the facility range from: high costs of services, to lack of transportation to/far distances of health facilities. These health concerns are possibly further exacerbated by poor quality of care at health facilities, and religious beliefs that drive women to unskilled/semi-skilled providers who put them at risk of losing their lives.

Development Hypothesis
In 2014, Pathfinder International, through the Evidence to Action (E2A) Project, began implementing the Saving Mothers, Giving Life (SMGL) Initiative across all 18 local government areas (LGAs) in CRS. Working with 108 facilities (78 public facilities and 30 private facilities), the initiative seeks to address the 3-Ds to accessing life-saving emergency obstetric care – delay in recognizing the need to seek care and making the decision to do so, delay in reaching services, and delay in receiving timely quality care. NB: USAID funds support work in the public and faith-based facilities, while funding for support to private health facilities is received from Merck for Mothers (MfM).

SMGL project hypothesizes that **IF** it intervenes in the 3 areas of delays, **THEN** there will be considerable reduction in maternal and child mortality. In addition, the Initiative hypothesizes **IF** it works to increase contraceptive prevalence, and reduce the unmet need for LARCs **THEN** there will be an improvement in maternal and newborn outcomes.

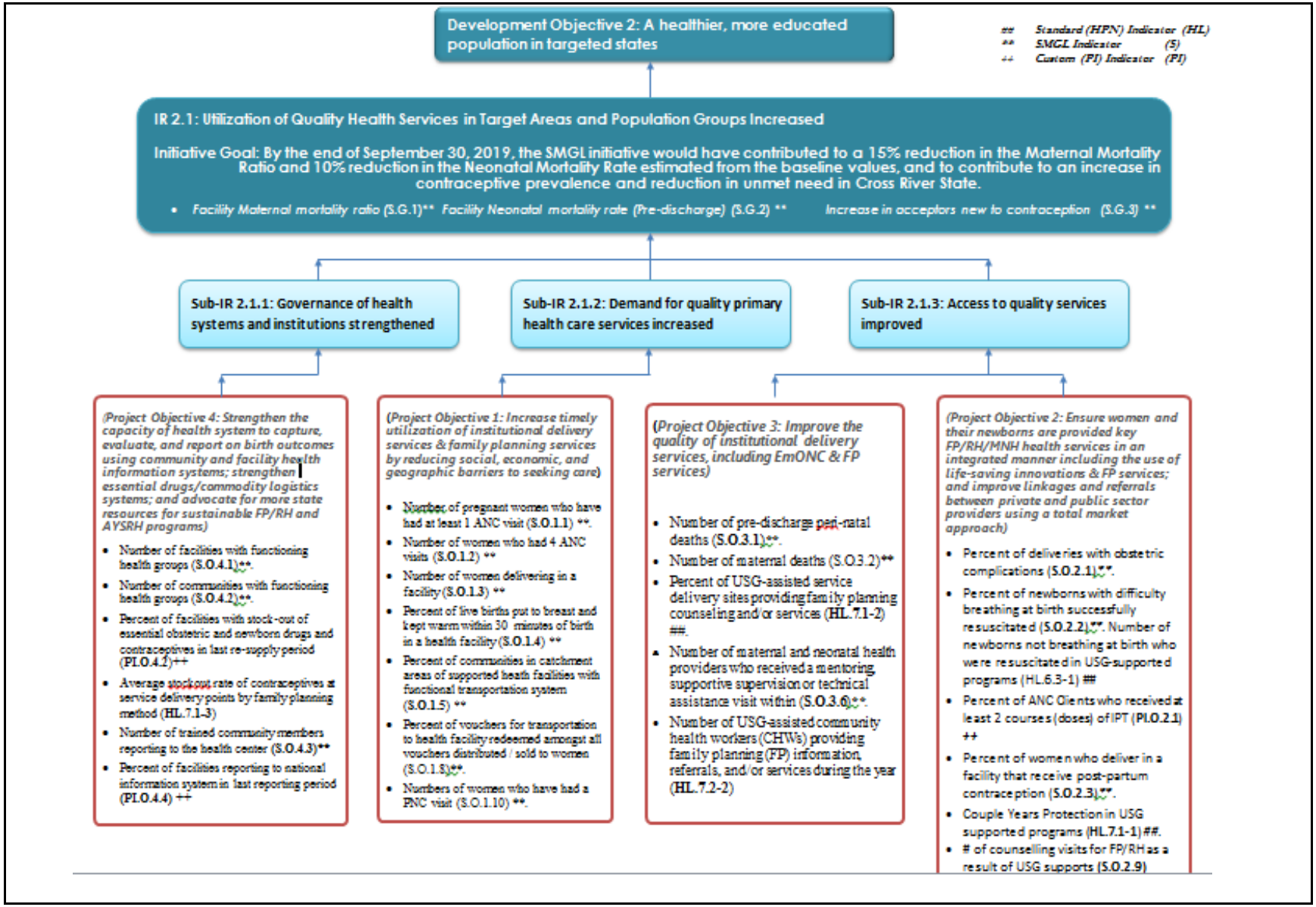
Critical Assumptions

The project postulated that the success in achieving the intended results is dependent on the following critical assumptions:

- Timely disbursement of obligated funds by USAID
- Politically stable and conflict-free programming State, and the Country at large.
- Professionally stable and industrial/strike free programming environments, and cooperation of relevant stakeholders.
- Favorable environmental and weather-related conditions such as storms, floods and erosion that have been known to impede travel and day-to-day activities.

Continuous political will by the all levels of Government (National, State and Local) to continue to support MNCH and other related public health programs.

Strategic or Results Framework for the project/program/intervention (*paste framework below*)



What is the geographic coverage and/or the target groups for the project or program that is the subject of analysis?

The SMGL project operates across all 18 local government areas (LGAs) in Cross River State. The project is implemented in public and private healthcare facilities. Direct beneficiaries of the project are pregnant women and infants who will be born without complications and women of reproductive age. Indirect beneficiaries include all residents in the Cross River State, and public healthcare workers, who would have their capacities built and thus be able to provide quality maternal and newborn care and FP services to their host communities.

IX. Purpose, Audience & Application

A. **Purpose**: Why is this evaluation being conducted (purpose of analytic activity)? Provide the specific reason for this activity, linking it to future decisions to be made by USAID leadership, partner governments, and/or other key stakeholders.

The purpose of this endline evaluation is to provide the United States Agency for International Development (USAID) Nigeria with a summative assessment of SMGL program implementation and measurable results in Nigeria. Specifically, this endline evaluation is being conducted to: ● To assess whether SMGL has achieved set objectives and expected outputs as stated in the SMGL agreement program description; ● To learn lessons on project implementation that address quality of service delivery of maternal and newborn health interventions, institutional delivery services, and comprehensive family planning services; ● To understand successes of implementation across the public and private health facilities in Cross River State; and ● Provide recommendations to USAID Nigeria for potential future investments in strategies and/or interventions that contributed to increasing coverage and quality of maternal, newborn, and reproductive health services in public, private and faith-based facilities.

B. **Audience**: Who is the intended audience for this analysis? Who will use the results? If listing multiple audiences, indicate which are most important.

USAID and Ministry of Health Stakeholders

C. **Applications and use**: How will the findings be used? What future decisions will be made based on these findings?

Provide recommendations to USAID Nigeria for potential future investments in strategies and/or interventions that contributed to changes in coverage and quality of maternal, newborn, and reproductive health services in public, private and faith-based facilities.

X. Evaluation/Analytic Questions & Matrix:

- Questions should be: a) aligned with the evaluation purpose and the expected use of findings; b) clearly defined to produce needed evidence and results; and c) answerable given the time and budget constraints. Include any disaggregation (e.g., sex, geographic locale, age, etc.), they must be incorporated into the evaluation questions. **USAID Evaluation Policy** recommends **1 to 5 evaluation questions.**
- State the method and/or data source and describe the data elements needed to answer the evaluation questions

	Evaluation Question	Suggested Data Sources	Suggested Data Collection Methods	Data Analysis Methods
1	To what extent has access to and utilization of evidence-based, high quality RMNCH interventions changed in SMGL-supported areas in Cross-River state? *Areas for consideration:* a) SMGL has provided technical assistance to CRSMoH, heads of supported facilities, and health care workers from public & private facilities. Note the extent to which this TA and/or engagement promoted the use of evidence-based RMNCH interventions b) Highlight critical relationships that facilitated project success c) The extent to which SMGL improved access to select 7 RMNCH interventions, and how it was done d) The best practices of the SMGL project that can be documented, should be scaled e) The critical support received/not received from USAID	Stakeholders, project reports, Baseline report, DHIS 2, facility registers.	Key informant interviews, FGDs, Survey, Desk review	[To be determined by evaluation team] [Requested level of disaggregation —Age, religion, gender, ethnicity, location (district, province), etc.…]
2	How have project implementation and its mode of delivery changed quality of service delivery of maternal and newborn health interventions and comprehensive family planning services? *Areas for consideration:* a) What ways has SMGL used data generated by the program to improve implementation?	Stakeholders' interviews, project reports, DQA reports, DHIS2 data, facility register.	Key informant interviews, desk review, Survey	

	Evaluation Question	Suggested Data Sources	Suggested Data Collection Methods	Data Analysis Methods
3	To what extent has SMGL incorporated gender strategies to improve accessibility and utilization of services? *Areas for consideration:* a) The affect gender roles have on care seeking and uptake of services b) The extent to which women can make decisions with regards to use of maternal and child services at sites with accessible RHMNCH interventions?	Stakeholders interviews, baseline report, project reports, DQA reports, DHIS2 data	Key informant interviews, desk review, Survey	
4	To what extent have state and local authorities made plans to sustain SMGL's interventions and activities in Cross-River State? *Areas for consideration:* a) Critical needs currently met by SMGL b) Government ownership c) Capacity to advocate for maintaining or expanding RMNCH in the State d) Physical infrastructure capable and sufficient to maintain or expand RMNCH efforts e) Supportive policy environment to maintain and/or expand RNMCH efforts f) What ways has the project strengthened formal links between private and public providers and facilities to addressing maternal and newborn health needs of the people (women of Cross River, and their families), and how does successes in project implementation compare between public and faith-based facilities?	Stakeholders, key government officials (traditional/community leaders, FMoH, SMOH, and NPHCDA)	Interviews, Survey	

	Evaluation Question	Suggested Data Sources	Suggested Data Collection Methods	Data Analysis Methods
5	To what extent has community structures contributed to changes in demand for, access and utilization of quality health delivery services in the targeted communities? *Areas for consideration:* a) The roles TBAs/ Patent and Proprietary Medicine Vendors (PPMVs) play in the target communities, to increase access to quality FP, labor, and health delivery services b) The ways that linkages to facility health delivery services increased or decreased in the supported health facilities	Stakeholders, head of supported facilities, health care providers, PHC coordinators	Key informant, Interviews, Survey	

Other Questions *[OPTIONAL]*
(***Note***: Use this space only if necessary. Too many questions leads to an ineffective evaluation or analysis.)

XI. Methods: Check and describe the recommended methods for this analytic activity. Selection of methods should be aligned with the evaluation questions and fit within the time and resources allotted for this analytic activity. Also, include the sample or sampling frame in the description of each method selected.

General Comments related to Methods: The Evaluation Team will determine the best methods that will provide the needed data to address the evaluation questions. Below are recommended methods for the Evaluation Team's consideration.

■ **Document and Data Review** (*list of documents and data recommended for review*)

This desk review will be used to provide background information on the project/program, and will also provide data for analysis for this evaluation. Documents and data to be reviewed include:

- Baseline assessment report
- Health facilities list
- SMGL project Monitoring and Evaluation Plan (including the project's results framework provided above)
- SMGL performance indicators reported on the USAID PRS
- SMGL quarterly and annual reports, trip reports, financial tracking reports, success stories, SMGL training materials and evaluations of SMGL trainings, etc.
- Current funding from USAID Nigeria
- SMGL Annual Work plans
- Reports on activities/training support to PHC coordinators, MDAs, CHEWS, nurses/midwives, TWGs and TBAs.
- DQA reports
- Mid-Term Evaluation Reports

- Nigeria MICS 2016-2017
- Nigeria DHS 2013

☐ **Secondary analysis of existing data** *(This is a re-analysis of existing data, beyond a review of data reports. List the data source and recommended analyses)*

Data Source (existing dataset)	Description of data	Recommended analysis

■ **Key Informant Interviews** *(list categories of key informants and purpose of inquiry)*

The evaluation team will conduct in-depth key informant and/or group interviews, at a minimum, with the following organizations/staff:

- SMGL/Nigeria project staff (Nigeria Office senior management and staff)
- SMGL Leadership in DC
- USAID HPN Office Leadership
- E2A AOR involved in SMGL
- USAID Activity Manager and other selected USAID program managers
- Subject matter experts, outside stakeholders, and other identified partners, including, but not limited to:
    - Heads of supported facilities
    - Health care workers from public & private facilities
    - Traditional leaders
    - WDC members
    - TBAs
    - Beneficiaries
    - CBO Executive Directors
    - ETS Stakeholders
    - PHC Coordinators
    - Cross-River State Primary Health Care Development Agency (CRSPHCDA)
    - Cross River State Ministry of Health (CRSMOH)
    - Society of Gynecology and Obstetrics of Nigeria (SOGON)
    - Nigerian Society of Neonatal Medicine (NISONM)

■ **Focus Group Discussions** *(list categories of groups, and purpose of inquiry)*

Optional: The Team may decide to conduct FGD among beneficiaries. Based on the questions to be asked a group interview may be a better method. However, some beneficiaries may not be comfortable talking in a group, so this should be taken into consideration as well. The Team will determine if

■ **Group Interviews** *(list categories of groups, and purpose of inquiry)*

Key informants may be interviewed in small groups of similar respondents, as long as all participants feel free to express their own opinions.

■ **Client/Participant Satisfaction or Exit Interviews** (*list who is to be interviewed, and purpose of inquiry*)

Conduct Client Exit Interviews to measure women's satisfaction in terms access to and utilization of evidence-based, high quality RMNCH interventions in SMGL-supported areas in Cross-River state

■ **Survey** *(describe content of the survey and target responders, and purpose of inquiry)*

The Team may want to consider a survey to assess health facility's capabilities, including commodities, staffing, infrastructure, etc. This will be discussed with USAID during the in-brief.

☐ **Facility or Service Assessment/Survey** *(list type of facility or service of interest, and purpose of inquiry)*

■ **Observations** *(list types of sites or activities to be observed, and purpose of inquiry)*

Clinics and EmONC sites should be visited during open hours when clients are more likely to visit. GIS coordinates of clinics should be noted. If Team cannot determine coordinates, they should get the clinic GIS coordinates from E2A/Nigeria.

☐ **Cost Analysis** *(list costing factors of interest, and type of costing assessment, if known)*

☐ **Data Abstraction** *(list and describe files or documents that contain information of interest, and purpose of inquiry)*

☐ **Case Study** *(describe the case, and issue of interest to be explored)*

☐ **Verbal Autopsy** *(list the type of mortality being investigated (i.e., maternal deaths), any cause of death and the target population)*

☐ **Rapid Appraisal Methods** *(ethnographic / participatory) (list and describe methods, target participants, and purpose of inquiry)*

☐ **Other** *(list and describe other methods recommended for this evaluation, and purpose of inquiry)*

If **impact evaluation** –

Is technical assistance needed to develop full protocol and/or IRB submission?

☐ Yes ☐ No

List or describe case and counterfactual"

Case	Counterfactual

XII. HUMAN SUBJECT PROTECTION

The Analytic Team must develop protocols to insure privacy and confidentiality prior to any data collection. Primary data collection must include a consent process that contains the purpose of the evaluation, the risk and benefits to the respondents and community, the right to refuse to answer any question, and the right to refuse participation in the evaluation at any time without consequences. Only adults can consent as part of this evaluation. **Minors cannot be respondents to any**

interview or survey, and cannot participate in a focus group discussion without going through an IRB. The only time minors can be observed as part of this evaluation is as part of a large community-wide public event, when they are part of family and community in the public setting. During the process of this evaluation, if data are abstracted from existing documents that include unique identifiers, data can only be abstracted without this identifying information.

An Informed Consent statement included in all data collection interactions must contain:

- Introduction of facilitator/note-taker
- Purpose of the evaluation
- Purpose of interview/discussion/survey
- Statement that all information provided is confidential and information provided will not be connected to the individual
- Right to refuse to answer questions or participate in interview/discussion/survey
- Request consent prior to initiating data collection (i.e., interview/discussion/survey)

XIII. ANALYTIC PLAN

Describe how the quantitative and qualitative data will be analyzed. Include method or type of analyses, statistical tests, and what data it to be triangulated (if appropriate). For example, thematic analyses of qualitative interview data, or a descriptive analysis of quantitative survey data.

All analyses will be geared to answer the evaluation questions. Additionally, the evaluation will review both qualitative and quantitative data related to the project/program's achievements against its objectives and/or targets.

Quantitative data will be analyzed primarily using descriptive statistics. Data will be stratified by demographic characteristics, such as sex, age, and location, whenever feasible. Other statistical test of association (i.e., odds ratio) and correlations will be run as appropriate.

Thematic review of qualitative data will be performed, connecting the data to the evaluation questions, seeking relationships, context, interpretation, nuances and homogeneity and outliers to better explain what is happening and the perception of those involved. Qualitative data will be used to substantiate quantitative findings, provide more insights than quantitative data can provide, and answer questions where other data do not exist.

Use of multiple methods that are quantitative and qualitative, as well as existing data (e.g., project/program performance indicator data, DHS, MICS, HMIS data, etc.) will allow the Team to triangulate findings to produce more robust evaluation results.

The Evaluation Report will describe analytic methods and statistical tests employed in this evaluation.

XIV. ACTIVITIES

List the expected activities, such as Team Planning Meeting (TPM), briefings, verification workshop with IPs and stakeholders, etc. Activities and Deliverables may overlap. Give as much detail as possible.

Background reading – Several documents are available for review for this analytic activity. These include SMGL/Nigeria annual work plans, M&E plans, quarterly progress reports, and routine reports of project performance indicator data, as well as survey data reports (i.e., DHS and MICS). This desk review will provide background information for the Evaluation Team, and will also be used as data input and evidence for the evaluation.

Team Planning Meeting (TPM) – A four-day team planning meeting (TPM) will be held at the initiation of this assignment and before the data collection begins. The TPM will:

- Review and clarify any questions on the evaluation SOW
- Clarify team members' roles and responsibilities
- Establish a team atmosphere, share individual working styles, and agree on procedures for resolving differences of opinion
- Review and finalize evaluation questions
- Review and finalize the assignment timeline
- Develop data collection methods, instruments, tools and guidelines
- Review and clarify any logistical and administrative procedures for the assignment
- Develop a data collection plan
- Draft the evaluation work plan for USAID's approval
- Develop a preliminary draft outline of the team's report
- Assign drafting/writing responsibilities for the final report

Briefing and Debriefing Meetings – Throughout the evaluation the Team Lead will provide briefings to USAID. The In-Brief and Debrief are likely to include the all Evaluation Team experts, but will be determined in consultation with the Mission. These briefings are:

- Evaluation **launch**, a call/meeting among the USAID, GH Pro and the Team Lead to initiate the evaluation activity and review expectations. USAID will review the purpose, expectations, and agenda of the assignment. GH Pro will introduce the Team Lead, and review the initial schedule and review other management issues.
- **In-brief with USAID**, as part of the TPM. At the beginning of the TPM, the Evaluation Team will meet with USAID to discuss expectations, review evaluation questions, and intended plans. The Team will also raise questions that they may have about the project/program and SOW resulting from their background document review. The time and place for this in-brief will be determined between the Team Lead and USAID prior to the TPM.
- **Workplan and methodology review briefing**. At the end of the TPM, the Evaluation Team will meet with USAID to present an outline of the methods/protocols, timeline and data collection tools. Also, the format and content of the Evaluation report(s) will be discussed.
- **In-brief with project** to review the evaluation plans and timeline, and for the project to give an overview of the project to the Evaluation Team.
- The Team Lead (TL) will brief the USAID **midterm**, as well as **weekly** updates, by phone or email (USAID's preference TBD), to discuss progress on the evaluation. As preliminary findings arise, the TL will share these during the routine briefing, and in an email.
- A **final debrief** between the Evaluation Team and USAID will be held at the end of the evaluation to present preliminary findings to USAID. During this meeting a summary of the data will be presented, along with high level findings and draft recommendations. For the debrief, the Evaluation Team will prepare a **PowerPoint Presentation** of the key findings, issues, and recommendations. If web-conferencing is feasible, USAID/DC will join the debrief with USAID. If connectivity is not good, the Team Lead will do a separate debrief with USAID/DC. If Team Lead is in DC this debrief will be in person; otherwise, GH Pro will arrange this debrief to be web-conferenced. The evaluation team shall incorporate comments received from USAID during the debrief in the evaluation report. (***Note****: preliminary findings are not final and as more data sources are developed and analyzed these finding may change.*)
- **IP and Stakeholders' debrief/workshop** will be held with the project staff and other stakeholders identified by USAID. This will occur following the final debrief with the Mission, and will not include any information that may be procurement deemed sensitive or not suitable by USAID.

Fieldwork, Site Visits and Data Collection – The evaluation team will conduct site visits to for data collection. Selection of sites to be visited will be finalized during TPM in consultation with USAID. The evaluation team will outline and schedule key meetings and site visits prior to departing to the field.

Evaluation/Analytic Report – The Evaluation/Analytic Team under the leadership of the Team Lead will develop a report with findings and recommendations (see Analytic Report below). Report writing and submission will include the following steps:

1. Team Lead will submit draft evaluation report to GH Pro for review and formatting
2. GH Pro will submit the draft report to USAID
3. USAID will review the draft report in a timely manner, and send their comments and edits back to GH Pro
4. USAID will manage implementing partner(s)'s (IP) review of the report and compile and send their comments and edits to GH Pro. (Note: USAID will decide what draft they want the IP to review.)
5. GH Pro will share USAID's comments and edits with the Team Lead, who will then do final edits, as needed, and resubmit to GH Pro
6. GH Pro will review and reformat the final Evaluation/Analytic Report, as needed, and resubmit to USAID for approval.
7. Once Evaluation Report is approved, GH Pro will re-format it for 508 compliance and post it to the DEC.

The Evaluation Report **excludes** any **procurement-sensitive** and other sensitive but unclassified (**SBU**) information. This information will be submitted in a memo to USIAD separate from the Evaluation Report.

Data Submission – All quantitative data will be submitted to GH Pro in a machine-readable format (CSV or XML). The datasets created as part of this evaluation must be accompanied by a data dictionary that includes a codebook and any other information needed for others to use these data. It is essential that the datasets are stripped of all identifying information, as the data will be public once posted on USAID Development Data Library (DDL).

Where feasible, qualitative data that do not contain identifying information should also be submitted to GH Pro.

XV. DELIVERABLES AND PRODUCTS

Select all deliverables and products required on this activity. For those not listed, add rows as needed or enter them under "Other" in the table below. Provide timelines and deliverable deadlines for each.

Deliverable / Product	Timelines & Deadlines (estimated)
■ Launch briefing	May 3, 2019
■ In-brief with USAID/W SMGL	TBD (before travel to Nigeria, if possible)
■ In-brief with USAID	May 9, 2019
■ Work plan and methodology review briefing	May 13, 2019
■ Work plan submitted (must include questions, methods, timeline, data analysis plan, and instruments)	May 14, 2019
■ In-brief with SMGL/Nigeria	May 15, 2019
■ Routine briefings	Weekly
■ Debrief with USAID with Power Point presentation (May require separate debrief with USAID and USAID/DC)	June 3, 2019

Deliverable / Product	Timelines & Deadlines (estimated)
■ IP & stakeholders findings review workshop with Power Point presentation	June 18, 2019
■ Draft report	*Submit to GH Pro*: July 8, 2019 *GH Pro submits to USAID*: July 19, 2019
■ Final report	*Submit to GH Pro*: August 23, 2019 *GH Pro submits to USAID*: August 30, 2019
■ Raw data (cleaned datasets in CSV or XML with codesheet)	August 1, 2019
■ Report Posted to the DEC	November 1, 2019

Holidays:

February 16, 2019	Nigerian General Elections (Nigeria)
February 18, 2019	Washington's Birthday (US)
April 19, 2019	Good Friday (Nigeria)
April 22, 2019	Easter Monday (Nigeria)
May 1, 2019	Workers' Day (Nigeria)
May 27, 2019	Memorial Day (US)
June 5-6, 2019	Id el Fitr (Nigeria
June 12, 2019	Democracy Day (Nigeria)

Estimated USAID review time
Average number of business days USAID will need to review the Report? 10
Business days

XVI. TEAM COMPOSITION, SKILLS AND LEVEL OF EFFORT (LOE)

Evaluation team: When planning this analytic activity, consider:

- Key staff should have methodological and/or technical expertise, regional or country experience, language skills, team lead experience and management skills, etc.
- Team leaders for evaluations/assessments must be an external expert with appropriate skills and experience.
- Additional team members can include research assistants, enumerators, translators, logisticians, etc.
- Teams should include a collective mix of appropriate methodological and subject matter expertise.
- Evaluations require an Evaluation Specialist, who should have evaluation methodological expertise needed for this activity. Similarly, other analytic activities should have a specialist with methodological expertise.
- Note that **all team members will be required to provide a signed statement attesting that they have no conflict of interest (COI)**, or describing the conflict of interest if applicable.

Team Qualifications: Please list technical areas of expertise required for this activity:

- *List desired qualifications for the team as a whole*
- *List the key staff needed for this analytic activity and their roles.*
- *Sample position descriptions are posted on USAID/GH Pro webpage*
- *Edit as needed GH Pro provided position descriptions*

Overall Team requirements:

Team Lead: This person will be selected from among the key staff, and will meet the requirements of both this and the other position. The team lead should have significant experience conducting project evaluations and/or assessments.
Roles & Responsibilities: The team leader will be responsible for (1) providing team leadership; (2) managing the team's activities, (3) ensuring that all deliverables are met in a timely manner, (4) serving as a liaison between the USAID and the evaluation team, and (5) leading briefings and presentations.
Qualifications:

- Minimum of 10 years of experience in public health, which included experience in implementation of health activities in developing countries
- Demonstrated experience leading health sector project/program evaluation/assessments, utilizing both quantitative and qualitative methods
- Excellent skills in planning, facilitation, and consensus building
- Excellent interpersonal skills, including experience successfully interacting with host government officials, civil society partners, and other stakeholders
- Excellent skills in project management
- Excellent organizational skills and ability to keep to a timeline
- Good writing skills, with extensive report writing experience
- Experience working in the region, and experience in Nigeria is desirable
- Familiarity with USAID
- Familiarity with USAID policies and practices
  - Evaluation policy
  - Results frameworks
  - Performance monitoring plans

Key Staff 1 Title: **Evaluation Specialist**
Roles & Responsibilities: Serve as a member of the evaluation team, providing quality assurance on analytic issues, including methods, development of data collection instruments, protocols for data collection, data management and data analysis. S/He will oversee the training of all engaged in data collection, insuring highest level of reliability and validity of data being collected. S/He is the lead analyst, responsible for all data analysis, and will coordinate the analysis of all data, assuring all quantitative and qualitative data analyses are done to meet the needs for this evaluation. S/He will participate in all aspects of the evaluation, from planning, data collection, data analysis to report writing.
Qualifications:

- At least 10 years of experience in USAID M&E procedures and implementation
- At least 5 years managing M&E, including evaluations and/or assessments
- Experience in design and implementation of evaluations and/or assessments
- Strong knowledge, skills, and experience in qualitative and quantitative analytic tools
- Experience implementing and coordinating others to implement surveys, key informant interviews, focus groups, observations and other evaluation and assessment methods that assure reliability and validity of the data.
- Experience in data management
- Able to analyze quantitative data, which will be primarily descriptive statistics and cross-tabulations
- Able to analyze qualitative data
- Experience using analytic software
- Demonstrated experience using qualitative evaluation methodologies, and triangulating with quantitative data
- Experience conducting secondary analysis of existing quantitative datasets

- Able to review, interpret and reanalyze as needed existing data pertinent to the evaluation
- Strong data interpretation and presentation skills
- Proficient in written and spoken English
- Good writing skills, including experience writing evaluation and/or assessment reports
- Familiarity with USAID health programs/projects, particularly in the area RMNCH
- Familiarity with USAID M&E policies and practices
  - Evaluation policies
  - Results frameworks
  - Performance monitoring plans

Key Staff 2 Title: **RMNCH Specialist**
Roles & Responsibilities: Serve as a member of the evaluation team, providing expertise in RMNCH. S/He will participate in planning and briefing meetings, data collection, data analysis, development of evaluation presentations, and writing of the Evaluation Report.
Qualifications:

- At least 8 years' experience with RMNCH projects; USAID project implementation experience preferred
- Expertise in supply and demand for RMNCH services at the community and clinical level
- Experience conducting evaluations or assessments, for USAID project/programs is preferred.
- Excellent interpersonal skills, including experience successfully interacting with host government officials, civil society partners, and other stakeholders
- Proficient in English
- Good writing skills, including experience writing evaluation and/or assessment reports
- Experience in conducting USAID evaluations of health programs/activities

Title: **Gender Specialist**
Roles & Responsibilities: Serve as a member of the evaluation team, providing expertise on gender issues gender issues related to health, including integration of gender into project/program development and implementation. S/He will participate in planning and briefing meetings, data collection, data analysis, development of evaluation presentations, and writing of the Evaluation Report.
Qualifications:

- Minimum of 10 years of experience in international development and gender
- Experience working internationally on gender and health programs/projects
- Experience in conducting gender analysis and/or assessments that include gender issues and gender programming within the health sector
- Expertise in analysis and understanding of local socio-cultural norms and structures, especially related to gender
- Excellent interpersonal skills, including experience successfully interacting with USAID, implementing partners, host government officials, civil society partners, and other stakeholders
- Good writing skills, with extensive report writing experience
- Knowledge of USAID and PEPFAR gender policies and strategies

Other Staff Titles with Roles & Responsibilities (include number of individuals needed):

Local **Evaluation Logistics/Program Assistant** will support the Evaluation Team with all logistics and administration to allow them to carry out this evaluation. The Logistics/Program Assistant will have a good command of English and local language(s). S/He will have knowledge of key actors in the health

sector and their locations including MOH, donors and other stakeholders. To support the Team, s/he will be able to efficiently liaise with hotel staff, arrange in-country transportation (ground and air), arrange meeting and workspace as needed, and insure business center support, e.g. copying, internet, and printing. S/he will work under the guidance of the Team Leader to make preparations, arrange meetings and appointments. S/he will conduct programmatic administrative and support tasks as assigned and ensure the processes moves forward smoothly. S/He may also be asked to assist in translation of data collection tools and transcripts, if needed.

Local Evaluators (2 consultants) to assist the Evaluation Team with data collection, analysis and data interpretation. They will have basic familiarity with health topics, as well as experience conducting surveys interviews and focus group discussion, both facilitating and note taking. Furthermore, they will assist in translation of data collection tools and transcripts, as needed. The Local Evaluators will have a good command of English and local language(s). They will also assist the Team and the Logistics Coordinator, as needed. **One of the Local Evaluators will have a strong background in gender**. The Local Evaluators will report to the Team Lead.

Will USAID participate as an active team member or designate other key stakeholders to as an active team member? This will require full time commitment during the evaluation or assessment activity.

☐ Full member of the Evaluation Team (including planning, data collection, analysis and report development) – If yes, specify who:
☐ Some Involvement anticipated – If yes, specify who:
■ No

Staffing Level of Effort (LOE) Matrix:

This LOE Matrix will help you estimate the LOE needed to implement this analytic activity. If you are unsure, GH Pro can assist you to complete this table.

a) For each column, replace the label "Position Title" with the actual position title of staff needed for this analytic activity.
b) Immediately below each staff title enter the anticipated number of people for each titled position.
c) Enter Row labels for each activity, task and deliverable needed to implement this analytic activity.
d) Then enter the LOE (estimated number of days) for each activity/task/deliverable corresponding to each titled position.
e) At the bottom of the table total the LOE days for each consultant title in the 'Sub-Total' cell, then multiply the subtotals in each column by the number of individuals that will hold this title.

Estimated Level of Effort in **days** for each Evaluation/Analytic Team member

Activity / Deliverable		Evaluation Team LOE (days)					
		Team Lead / Gender Spec	RMNCH Spec	Eval Spec	Local Gender Spec	Local Evaluator	Logistics/ Prog Assist
1	Launch Briefing	0.5					
2	HTSOS Training	1	1				
3	Desk review	5	5	5	3	3	
4	Preparation for Team convening in-country						5
5	Travel to country	2	2				
6	In-brief with Mission	0.5	0.5	0.5	0.5	0.5	0.5
7	Team Planning Meeting	4	4	4	4	4	4
8	Workplan and methodology briefing with USAID	0.5	0.5	0.5	0.5	0.5	0.5

Activity / Deliverable		Evaluation Team LOE (days)					
		Team Lead / Gender Spec	RMNCH Spec	Eval Spec	Local Gender Spec	Local Evaluator	Logistics/ Prog Assist
9	Eval planning deliverables: 1) workplan with timeline, eval matrix, protocol (methods, sampling & analytic plan); 2) data collection tools						
10	In-brief with SMGL/Nigeria	0.5	0.5	0.5	0.5	0.5	0.5
11	Data Collection DQA Workshop (protocol orientation/training for all data collectors)	2	2	2	2	2	
12	Prep / Logistics for Site Visits	0.5	0.5	0.5	0.5	0.5	2.5
13	Data collection / Site Visits (including travel to sites)	12	12	12	12	12	12
14	Data analysis	7.5	7	7	7	7	7
15	Debrief with Mission with prep	1	1	1	1	1	1
16	IP & Stakeholder debrief workshop with prep	1	1	1	1	1	1
17	Depart country	2	2				
18	Draft report(s)	8	7	7	7	3	3
19	GH Pro Report QC Review & Formatting						
20	Submission of draft report(s) to Mission						
21	USAID Report Review						
22	Revise report(s) per USAID comments	4	3	3	2	2	
23	Finalize and submit report to USAID						
24	USAID approves report						
25	Final copy editing and formatting						
26	508 Compliance editing						
	Eval Report(s) to the DEC						
	Total Estimated LOE per person	**52**	**49**	**44**	**41**	**37**	**37**

If overseas, is a 6-day workweek permitted ■ Yes ☐ No
If traveling to or from place of performance, a 7-day workweek is permitted to allow the consultant to bill for actual travel time, up to 8 hours per day ■ Yes ☐ No

Travel anticipated: List international and local travel anticipated by what team members.

Nigeria: Abuja and Cross River State

XVII. LOGISTICS

Visa Requirements
List any specific Visa requirements or considerations for entry to countries that will be visited by consultant(s):

Visa needed for Nigeria. Consultant must apply for and pay for the Nigerian visa online. Following this s/he will need to set up an appointment with the designated Nigerian visa processing office. Expedited visas take a minimum of one week once the passport is dropped off at the visa processing office (per appointment).

List recommended/required type of Visa for entry into counties where consultant(s) will work

Name of Country	Type of Visa		
Nigeria	☐ Tourist	■ Business	☐ No preference
	☐ Tourist	☐ Business	☐ No preference

Clearances & Other Requirements

Note: Most Evaluation/Analytic Teams arrange their own work space, often in conference rooms at their hotels. However, if a Security Clearance or Facility Access is preferred, GH Pro can submit an application for it on the consultant's behalf.

GH Pro can obtain **Facility Access (FA)** and transfer existing **Secret Security Clearance** for our consultants, but please note these requests, processed through AMS at USAID/GH (Washington, DC), can take 4-6 months to be granted. If you are in a Mission and the RSO is able to grant a temporary FA locally, this can expedite the process. FAs for non-US citizens or Green Card holders must be obtained through the RSO. If FA or Security Clearance is granted through Washington, DC, the consultant must pick up his/her badge in person at the Office of Security in Washington, DC, regardless of where the consultant resides or will work.

If **Electronic Country Clearance (eCC)** is required prior to the consultant's travel, the consultant is also required to complete the **High Threat Security Overseas Seminar (HTSOS).** HTSOS is an interactive e-Learning (online) course designed to provide participants with threat and situational awareness training against criminal and terrorist attacks while working in high threat regions. There is a small fee required to register for this course. [*Note: The course is not required for employees who have taken FACT training within the past five years or have taken HTSOS within the same calendar year.*]

If eCC is required, and the consultant is expected to work in country more than 45 consecutive days, the consultant may be required complete the one week **Foreign Affairs Counter Threat (FACT) course** offered by FSI in West Virginia. This course provides participants with the knowledge and skills to better prepare themselves for living and working in critical and high threat overseas environments. Registration for this course is complicated by high demand (consultants must register approximately 3-4 months in advance). Additionally, there will be the cost for additional lodging and M&IE to take this course.

Check all that the consultant will need to perform this assignment, including USAID Facility Access, GH Pro workspace and travel (other than to and from post).

☐ USAID Facility Access (FA)
Specify who will require Facility Access: _____

☐ Electronic County Clearance (ECC) (International travelers only)
■ High Threat Security Overseas Seminar (HTSOS) (*required in most countries with ECC*)
☐ Foreign Affairs Counter Threat (FACT) (for consultants working on country more than 45 consecutive days)

☐ GH Pro workspace
Specify who will require workspace at GH Pro: _____

☐ Travel -other than posting (specify): Travel to Nigeria and to Cross River for data collection
☐ Other (specify): _____

Specify any country-specific **security concerns and/or requirements**

XVIII. GH PRO ROLES AND RESPONSIBILITIES

GH Pro will coordinate and manage the evaluation/assessment team and provide quality assurance oversight, including:

- Review SOW and recommend revisions as needed
- Provide technical assistance on methodology, as needed
- Develop budget for analytic activity
- Recruit and hire the evaluation/assessment team, with USAID POC approval
- Arrange international travel and lodging for international consultants
- Request for country clearance and/or facility access (if needed)
- Review methods, workplan, analytic instruments, reports and other deliverables as part of the quality assurance oversight
- Report production - If the report is public, then coordination of draft and finalization steps, editing/formatting, 508ing required in addition to and submission to the DEC and posting on GH Pro website. If the report is internal, then copy editing/formatting for internal distribution.

XIX. USAID ROLES AND RESPONSIBILITIES

Below is the standard list of USAID's roles and responsibilities. Add other roles and responsibilities as appropriate.

USAID Roles and Responsibilities

D will provide overall technical leadership and direction for the analytic team throughout the assignment and will provide assistance with the following tasks:

Field Work

- SOW.
  - Develop SOW.
  - Peer Review SOW
  - Respond to queries about the SOW and/or the assignment at large.
- Consultant Conflict of Interest (COI). To avoid conflicts of interest or the appearance of a COI, review previous employers listed on the CV's for proposed consultants and provide additional information regarding potential COI with the project contractors evaluated/assessed and information regarding their affiliates.
- Documents. Identify and prioritize background materials for the consultants and provide them to GH Pro, preferably in electronic form, at least one week prior to the inception of the assignment.
- Local Consultants. Assist with identification of potential local consultants, including contact information.
- Site Visit Preparations. Provide a list of site visit locations, key contacts, and suggested length of visit for use in planning in-country travel and accurate estimation of country travel line items costs.
- Lodgings and Travel. Provide guidance on recommended secure hotels and methods of in-country travel (i.e., car rental companies and other means of transportation).

g Field Work

- Mission Point of Contact. Throughout the in-country work, ensure constant availability of the Point of Contact person and provide technical leadership and direction for the team's work.
- Meeting Space. Provide guidance on the team's selection of a meeting space for interviews and/or focus group discussions (i.e. USAID space if available, or other known office/hotel meeting space).
- Meeting Arrangements. Assist the team in arranging and coordinating meetings with stakeholders.
- Facilitate Contact with Implementing Partners. Introduce the analytic team to implementing partners and other stakeholders, and where applicable and appropriate prepare and send out an introduction letter for team's arrival and/or anticipated meetings.

Field Work

- Timely Reviews. Provide timely review of draft/final reports and approval of deliverables.

XX. ANALYTIC REPORT

Provide any desired guidance or specifications for Final Report. (See *How-To Note: Preparing Evaluation Reports*)

The **Evaluation/Analytic Final Report** must follow USAID's Criteria to Ensure the Quality of the Evaluation Report (found in Appendix I of the USAID Evaluation Policy).

- The report should not exceed 25 pages (excluding executive summary, table of contents, acronym list and annexes).
- The structure of the report should follow the Evaluation Report template, including branding found here or here.
- Draft reports must be provided electronically, in English, to GH Pro who will then submit it to USAID.
- For additional Guidance, please see the Evaluation Reports to the How-To Note on preparing Evaluation Draft Reports found here.

USAID Criteria to Ensure the Quality of the Evaluation Report (USAID ADS 201):

- Evaluation reports should be readily understood and should identify key points clearly, distinctly, and succinctly.
- The Executive Summary of an evaluation report should present a concise and accurate statement of the most critical elements of the report.
- Evaluation reports should adequately address all evaluation questions included in the SOW, or the evaluation questions subsequently revised and documented in consultation and agreement with USAID.
- Evaluation methodology should be explained in detail and sources of information properly identified.
- Limitations to the evaluation should be adequately disclosed in the report, with particular attention to the limitations associated with the evaluation methodology (selection bias, recall bias, unobservable differences between comparator groups, etc.).
- Evaluation findings should be presented as analyzed facts, evidence, and data and not based on anecdotes, hearsay, or simply the compilation of people's opinions.
- Findings and conclusions should be specific, concise, and supported by strong quantitative or qualitative evidence.
- If evaluation findings assess person-level outcomes or impact, they should also be separately assessed for both males and females.
- If recommendations are included, they should be supported by a specific set of findings and should be action-oriented, practical, and specific.

Reporting Guidelines: The draft report should be a comprehensive analytical evidence-based evaluation report. It should detail and describe results, effects, constraints, and lessons learned, and provide recommendations and identify key questions for future consideration. The report shall follow USAID branding procedures. ***The report will be edited/formatted and made 508 compliant as required by USAID for public reports and will be posted to the USAID/DEC.***

The findings from the evaluation will be presented in a draft report at a full briefing with USAID and at a follow-up meeting with key stakeholders. The report should use the following format:

- Abstract: briefly describing what was evaluated, evaluation questions, methods, and key findings or conclusions (not more than 250 words)
- Executive Summary: summarizes key points, including the purpose, background, evaluation questions, methods, limitations, findings, conclusions, and most salient recommendations (2-5 pages)
- Table of Contents (1 page)

- Acronyms
- Evaluation/Analytic Purpose and Evaluation/Analytic Questions: state purpose of, audience for, and anticipated use(s) of the evaluation (1-2 pages)
- Project [or Program] Background: describe the project/program and the background , including country and sector context, and how the project/program addresses a problem or opportunity (1-3 pages)
- Evaluation/Analytic Methods and Limitations: data collection, sampling, data analysis and limitations (1-3 pages)
- Findings (organized by Evaluation/Analytic Questions): substantiate findings with evidence/data
- Conclusions
- Recommendations
- Annexes
    - Annex I: Evaluation/Analytic Statement of Work
    - Annex II: Evaluation/Analytic Methods and Limitations ((if not described in full in the main body of the evaluation report)
    - Annex III: Data Collection Instruments
    - Annex IV: Sources of Information
        - List of Persons Interviews
        - Bibliography of Documents Reviewed
        - Databases
        - [etc.]
    - Annex V: Statement of Differences (if applicable)
    - Annex VI: Disclosure of Any Conflicts of Interest
    - Annex VII: Summary information about evaluation team members, including qualifications, experience, and role on the team.

The evaluation methodology and report will be compliant with the USAID Evaluation Policy and Checklist for Assessing USAID Evaluation Reports

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The Evaluation Report should **exclude** any **potentially procurement-sensitive information**. As needed, any procurement sensitive information or other sensitive but unclassified (SBU) information will be submitted in a memo to USIAD separate from the Evaluation Report.

All data instruments, data sets (if appropriate), presentations, meeting notes and report for this evaluation/analysis will be submitted electronically to the GH Pro Program Manager. All datasets developed as part of this evaluation will be submitted to GH Pro in an unlocked machine-readable format (CSV or XML). The datasets must not include any identifying or confidential information. The datasets must also be accompanied by a data dictionary that includes a codebook and any other information needed for others to use these data. Qualitative data included in this submission should not contain identifying or confidential information. Category of respondent is acceptable, but names, addresses and other confidential information that can easily lead to identifying the respondent should not be included in any quantitative or qualitative data submitted.

XXI. USAID CONTACTS

	Primary Contact	Alternate Contact 1	Alternate Contact 2
Name:	Amobi Andrew Onovo	Gertrude Odezugo	Vathani Amirthanayagam
Title:	Monitoring and Evaluation Specialist	Senior Reproductive Health Manager; SMGL Activity Manager	Acting Reproductive, Maternal, Newborn & Child Health Team Lead
USAID Mission	Nigeria/HPN	Nigeria/HPN	HPN/Nigeria
Email:	aonovo@usaid.gov	godezugo@usaid.gov	vamirthanayagam@usaid.gov
Telephone:			+234 9 461 9381
Cell Phone:	+234-703-0538954	+234 -810-248-4364	+234 (0) 806-843-8794

List other contacts who will be supporting the Requesting Team with technical support, such as reviewing SOW and Report (such as USAID/W GH Pro management team staff)

	Technical Support Contact 1	Technical Support Contact 2
Name:	Patricia (Trish) MacDonald	Claudia Morrissey Conlon, MD, MPH
Title:	Sr. FP/RH Technical Advisor	USAID Senior Maternal and Newborn Health Advisor; USG Lead, Saving Mothers, Giving Life
USAID Office:	GH/PRH	GH/MCHN, Maternal Newborn Division
Email:	pmacdonald@usaid.gov	cconlon@usaid.gov
Telephone:	571-551-7026	571 551 7497
Cell Phone:	571-232-6594	571 216 8944

XXII. OTHER REFERENCE MATERIALS

Documents and materials needed and/or useful for consultant assignment, that are not listed above

XXIII. ADJUSTMENTS MADE IN CARRYING OUT THIS SOW AFTER APPROVAL OF THE SOW (*To be completed after Assignment Implementation by GH Pro*)

ANNEX II. EVALUATION METHODS: INDICATORS

SMGL INDICATORS ANALYZED FOR THE EVALUATION

S/No	Indicators
1	SMGL Indicators
2	Number of facilities strengthened to provide quality care
3	Number of providers trained in BEmONC and/or CEmONC (disaggregated by male and female)
4	Number of community health extension workers trained (disaggregated by male and female)
5	Number of PFP facilities receiving subsidized commodities through MOH in exchange for sliding scale pricing
6	Number of women attending postnatal care visits
7	Number of women receiving PPFP counseling
8	Number of deliveries
9	Number of maternal deaths
10	Number of women reached via community outreach and education
11	Number of health groups (number of communities with functioning health groups)
12	Number of communities in catchment areas of supported health facilities with functional transportation system.
13	Number of providers/community health workers trained (disaggregated by male and female)
14	Number of women delivering in facilities providing high quality care
15	Number of women with improved access to quality care
16	Facility Maternal mortality ratio : Deaths of women relating to pregnancy
17	Facility peri-natal mortality rate (pre-discharge PMR) Livebirths: Pre-discharge perinatal deaths:
18	Number of women delivering in supported facilities (# of deliveries)
19	Number of C-sections performed in CEmONC facilities
20	Number of Live births put to breast and kept warm within 30minutes of birth
21	Number of newborns not breathing at birth successfully resuscitated
22	Number of pregnant women who have had at least 1 ANC visit
23	Number of women who have had 4 ANC visits
24	Number of women who delivered in the facility /who received FP counsellling prior to discharge
25	Number of deliveries with Ante Partum Hemorrhage
26	Number of deliveries with postpartum Hemorrhage
27	Number of deliveries with retained product of conception
28	Number of deliveries with prolonged / Obstructed labor
29	Number of deliveries with severe pre-/eclamptic toxemia
30	Number of deliveries with ectopic pregnancy
31	Number of deliveries with ruptured uterus
32	Number of deliveries with sepsis (SEP)
33	Number of women giving birth who received uterotonics in the third stage of labor (or immediately after birth) through USG-supported programs

S/No	Indicators
34	Number of newborns not breathing at birth who were resuscitated in USG-supported programs
35	Number of deliveries taking place in health facilities
36	Number of Medically Appropriate C- sections
37	Number of Mother-to-Child HIV transmission during delivery
38	Number of EmONC Case Fatality rate
39	Number of women who had a companion present in labor or delivery
40	Number of women able to explain the reason for receiving a treatment for complication (cesarean section, episiotomy, etc.)
41	Number of women who were draped during examinations
42	Number of HIV-positive pregnant women who received ARV prophylaxis for PMTCT (including HIV-positive women who were already on treatment elsewhere and came in for ANC and/or Labor and Delivery
43	Number of pregnant women who received HIV counseling and testing and received test results (including known HIV status at entry to services)
44	Number of HIV-positive pregnant women identified in the reporting period (including known HIV-positive at entry)
45	Number of live births
46	Number of Still births
47	Percentage of facilities where BEmONC services have been performed in last 3 months
48	Percent of facilities reporting to national information system in last reporting period
49	Number of mothers and their newborns who received postnatal care
50	Percent of deliveries with obstetric complications
51	Percent of ANC Clients who received at least 2 courses (doses) of IPT
52	Percent of women who deliver in a facility that receive post-partum contraception
53	Number of pregnant women who received at least two doses of tetanus-toxoid vaccine (TT2)
54	Percent / Number of pregnant women with known HIV status
55	Percent / Number of HIV-positive pregnant women who receive ARVs or ART to reduce mother-to-child-transmission during pregnancy and delivery.
56	Percent of infants born to HIV-positive women who received an HIV test within 2 months of birth
57	Percent / Number of HIV-positive women who begin using a modern method of FP following birth
58	Number of newborn infants receiving antibiotic treatment for infection through USG-supported programs (Pre-discharge)
59	Number of referrals for LARCs, other RH services
60	Number of clients accepting FP methods
61	Number of pregnant women reached with nutrition-specific interventions through USG-supported programs
62	Percent of USG-assisted service delivery sites providing family planning counseling and/or services (Number of facilities where FP/PPFP have been offered in the last 3 months)
64	Number of maternal and neonatal health providers who received a mentoring, supportive supervision or technical assistance visit within last 3 months.

ANNEX III. DATA COLLECTION INSTRUMENTS

TOOL 01: INTERVIEW GUIDE FOR SPOUSES (PARTNERS) OF WOMEN WHO HAVE GIVEN BIRTH IN SMGL FACILITIES

Informed Consent Paragraph

USAID has requested that GHPRO, a US-based consulting firm conduct a final evaluation of Saving Mothers Giving Life activities in Cross River State during the last five years. As members of the GHPRO team, we are interested in learning about the project and how it has affected access and utilization of maternal and neonatal health care in the state. We would like to request your participation in this evaluation. You may have been directly involved with this program, or you may have no knowledge of this program. In either case, your participation will be helpful in assessing how effective this program was, and to seek ways to improve programs like this in the future. We thank you for all the support that you have provided to us as a team. We want to assure you that information gathered will not be attributed to an individual or a team (unless we ask for permission to quote you).

- *We also would like to take photos of our meetings for our reports-is this OK?*
- *Do we have your permission to begin this interview?*
- *There is no remuneration provided for your participation, but if you become uncomfortable at any time, you may request that we stop the interview, or you are welcome to withdraw from the group.*
- *Do you have any questions before we start?*

INTERVIEW DATA			
Facilitator	**Note taker**	**Date of Interview**	**Recording #**
State	**LGA**	**Ward**	**Village**

PARTICIPANT INFORMATION		
Name of Interviewee: **If done in a group:** **Type of Participants Interviewed** **Positions of Participants represented at the interview:** Total Number of Participants: _____ M:_____ F:_____	**Interview Tape Recorded (Please check)** Yes_____ No_____	**Informed consent agreement:** **Yes:**_____ **No:**_____ **Consent for Photo:** **Yes**_____ **No**_____

Codes for questions and IRs		Comments
	1. Please can you describe the extent to which you were involved in your partner's pregnancy up until delivery?	
	2. With your most recent child, where did your partner attend your partner attend ANC and delivered the baby?	

	3. How was the decision for her to go to a healthcare facility made? And what influenced the decision?
	• How soon after labor pains began, did she decide to go to the health facility?
	• What kinds of difficulties did your partner (wife) in getting to the health facility?
	• How was her reception when she arrived at the health facility?
	  • Friendly
	  • Angry
	  • Brusque
	  • Other?	

	4. In your experience, were you satisfied with the care and treatment given to your partner during ANC and delivery at the healthcare facility?	
	5. How can the ANC and delivery services at the health facility be improved?	
	6. What is your idea about family planning (FP)?	
	7. Who in your household makes decisions about: • seeking health care? • making major household purchases? • making purchases for daily household needs? • visits to family or relatives? • How many children to have?	
	8. Can you describe any changes in your actions in support of your partner now that you didn't do before her most recent pregnancy and birth?	
	9. What changes have you experienced that would enhanced or hindered the use of healthcare for maternal health services?	

	10. Which activities do you think have contributed to these changes? Probe for; a. Sensitization 11. Counselling (PPMVs, CHEWS, CHVs etc)	
	12. What would you want to see done differently that would enhance women access to increase quality FP, labor and health delivery Service?	
	13. Can you describe any changes in your actions in support of your partner now that you didn't do before her most recent pregnancy and birth?	
	14. What changes have you experienced that would enhanced or hindered the use of healthcare for maternal health services?	
	15. Which activities do you think have contributed to these changes? Probe for; b. Sensitization 16. Counselling (PPMVs, CHEWS, CHVs etc)	
	17. What would you want to see done differently that would enhance women access to increase quality FP, labor and health delivery Service?	
	18. Do you have anything else to add?	

Thank you for sharing your thoughts and opinions with us today. We greatly appreciate the time you took to speak to us.

TOOL 02 - KII INTERVIEW GUIDE FOR SMGL COMMUNITY WOMEN WHO HAVE GIVEN BIRTH IN SMGL FACILITIES

Informed Consent Paragraph

USAID has requested that GHPRO, a US-based consulting firm conduct a final evaluation of Saving Mothers Giving Life activities in Cross River State during the last five years. As members of the GHPRO team, we are interested in learning about the project and how it has affected access and utilization of maternal and neonatal health care in the state. We would like to request your participation in this evaluation. You may have been directly involved with this program, or you may have no knowledge of this program. In either case, your participation will be helpful in assessing how effective this program was, and to seek ways to improve programs like this in the future. We thank you for all the support that you have provided to us as a team. We want to assure you that information gathered will not be attributed to an individual or a team (unless we ask for permission to quote you).

- *We also would like to take photos of our meetings for our reports-is this OK?*
- *Do we have your permission to begin this interview?*
- *There is no remuneration provided for your participation, but if you become uncomfortable at any time, you may request that we stop the interview, or you are welcome to withdraw from the group.*
- *Do you have any questions before we start?*

<table>
<tr><td colspan="4">INTERVIEW DATA</td></tr>
<tr><td>Facilitator</td><td>Note taker</td><td>Date of Interview</td><td>Recording #</td></tr>
<tr><td>State</td><td>LGA</td><td>Ward</td><td>Village</td></tr>
<tr><td colspan="4">PARTICIPANT INFORMATION</td></tr>
<tr><td colspan="2">Name of Interviewee:

If done in a group:
Type of Participants Interviewed

Positions of Participants represented at the interview:

Total Number of Participants: _____
M:_____
F:_____</td><td>Interview Tape Recorded (Please check)

Yes_____
No_____</td><td>Informed consent agreement:

Yes:_____
No:_____

Consent for Photo:

Yes_____

No_____</td></tr>
</table>

Codes for questions and IRs	Pre-interview question: When did you have your most recent child?	Comments
Background	1. During your pregnancy, what kind of support did you receive? And who provided the support? Probe for: a. Sensitization to visit healthcare facility b. ANC c. Counselling at healthcare facility d. Free delivery kits e. Transportation to healthcare facility f. Hello mama text messaging & phone calls g. Referrals to healthcare facility	
	2. Who provided you with support? Who are the key groups/individuals that provided you support (mentioned in Q1 above) during pregnancy and delivery? Probe for: a. Community Health Volunteers b. PPMVs c. TBAs d. WDC e. CHEWS f. ETS drivers g. Midwives in the community h. VDC i. Spouse (Husbands) j. Mother – in – laws k. Older women l. CBOs	
	3. Who are the people and organizations that support women during pregnancy and post-partum in the community? In what way do they help? a. Hello Mama Text Messaging or Phone calls b. Discussions with spouses (Husbands) c. Outreach to households by CHV, TBAs d. Community/Village meetings e. Church services f. Phone Calls (ETS, WDC Focal Person, VDC etc)	
	4. How frequently did you attend ANC during your last pregnancy?	
	5. Where did you deliver? Is this the same health facility you went to for ANC?	
	6. Who made the decision for you to attend the healthcare facility for: • ANC • Delivery • Post-partum care • Family Planning	
	7. What influences your decision to attend a healthcare facility? Probe for;	

	a. ANC b. Delivery c. Counselling d. Use ETS	
	8. How did you get to the health facility? 9.	
	10. What problems did you have in getting to the health facility?	
	11. When did you decide to come to the health facility: (ANC, labor & delivery, etc)	
	12. How soon after labor pains began did you decide to go to the health facility?	
	13. Who decided you should come to the health facility?	
	14. Who advised you not to seek care at the health facility?	
	15. Who in your household makes decisions about: • seeking health care? • making major household purchases? • making purchases for daily household needs? • visits to family or relatives? • How many children to have?	
	16. How long would you like to wait until having another child?	
	17. What are the best ways for you to prevent having a pregnancy before that time?	
	18. How do you feel about Family Planning	
	19. In your experience, were you satisfied with the care and treatment your received during ANC and delivery at the healthcare facility? 20. How can the services be improved?	
	21. What have been the most notable changes in women's and men's actions and practices that you have noticed regarding use of maternal and neonatal healthcare services? For • Women • Men • Community Leaders • WDC members • Transport Drivers • Healthcare Providers • Religious leaders • Other community leaders	
	22. Which activities do you think have contributed to these changes?	
	23. What role did your partner play in the care of your Newborn baby?	
	24. As a woman, what are the specific challenges you face accessing ANC and delivery services in a healthcare facility? Probe for;	

	• Distance/transportation • Cultural beliefs/tradition • Unfriendly attitudes at healthcare facilities	
	25. What would you want to see done differently that has the potential to increase access to quality FP, labour and health delivery Service?	
	26. Please describe how you intend to continue use of healthcare facility for ANC and delivery.	
	27. Any other information you want to share for improving programming and delivery of similar project.	

Thank you for sharing your thoughts and opinions with us today. We greatly appreciate the time you took to speak to us.

TOOL 03 - INTERVIEW GUIDE FOR SMGL CBO DIRECTORS

Informed Consent Paragraph

USAID has requested that GHPRO, a US-based consulting firm conduct a final evaluation of Saving Mothers Giving Life activities in Cross River State during the last five years. As members of the GHPRO team, we are interested in learning about the project and how it has affected access and utilization of maternal and neonatal health care in the state. We would like to request your participation in this evaluation. You may have been directly involved with this program, or you may have no knowledge of this program. In either case, your participation will be helpful in assessing how effective this program was, and to seek ways to improve programs like this in the future. We thank you for all the support that you have provided to us as a team. We want to assure you that information gathered will not be attributed to an individual or a team (unless we ask for permission to quote you).

- *We also would like to take photos of our meetings for our reports-is this OK?*
- *Do we have your permission to begin this interview?*
- *There is no remuneration provided for your participation, but if you become uncomfortable at any time, you may request that we stop the interview, or you are welcome to withdraw from the group.*
- *Do you have any questions before we start?*

INTERVIEW DATA			
Facilitator	**Note taker**	**Date of Interview**	**Recording #**
n	**LGA**	**Ward**	**Village**

PARTICIPANT INFORMATION		
Name of Person Interviewed **Positions of Participants represented at the interview:** Total Number of Participants: **M** _____ **F**: _____	**Interview Tape Recorded (Please check)** Yes _____ No _____	**Informed consent agreement:** **Yes:** _____ **No:** _____ **Consent for a Photo:** **Yes**_____ **No**_____

Codes for questions	*"I am going to be asking about your work with SMGL/E2A, maternal and newborn health, and other related activities"* *Ask them what term they use for SMGL and how it is referred to by the people they work with.*	**Comments**
EQs 3 and 4;	1. Can you describe the role of your organization on the SMGL Project?	
EQs 3 and 4; IR 1	2. What are the specific set of activities related to maternal and newborn health that you implemented in the communities?	
E3 and E5	3. Who are the key stakeholders that you work with in? • The ward (men/women) • Community (men/women)	
E3 and E5	4. How frequently does your organization interact with community groups in a specific place in one year, especially related to SMGL & maternal and newborn health issues?	

	• Ward Development committees? • Community leaders (women and men) • Groups of women? • Groups of men? • Individual households • Individual men and women	
E3	5. Can you describe how your CBO has engaged with women and men to reduce the delays that affect the demand for and use of maternal and neonatal health services? • ANC/ PMTCT • Labor and delivery care (EmONC) • Post-partum care • FP	
E3	6. What have been the most notable changes among project participants in relation to maternal and neonatal healthcare? • Women's agency and decision making • Men's engagement and support to women's and newborn healthcare need? • Community Leaders' behavior	
E3	7. Which of your organization's activities do you think have contributed to these changes?	
E3	8. What have been the biggest challenges or barriers in changing behavior and practice supportive of use of: • ANC • Labor and Delivery (access to BemONC and CemONC) • Post- partum • FP • Newborn care	
E3	9. What have been the most important changes in relationships among stakeholders that have facilitated uptake of services? Who were the key actors and facilitators of building these relationships?	
E3 and E5	10. What factors are most important for sustaining the changes that have occurred as a result of SMGL? How likely do you think these changes will be sustained after the project ends?	
	11. In your opinion what has been the most significant contribution of the SMGL project in reducing the 3 delays in Cross River State?	
	12. Is there anything else you would like to share about your experience with SMGL?	

Thank you for sharing your thoughts and opinions with us today. We greatly appreciate the time you took to speak to us.

TOOL 04 - INTERVIEW GUIDE FOR SMGL COMMUNITY BASED ACTOR(S) (CBAs) – -e.g., PPMVS, TBAS, CHVS, HELLOMAMA VOLUNTEERS, ETS DRIVERS *Informed Consent Paragraph*

USAID has requested that GHPRO, a US-based consulting firm conduct a final evaluation of Saving Mothers Giving Life activities in Cross River State during the last five years. As members of the GHPRO team, we are interested in learning about the project and how it has affected access and utilization of maternal and neonatal health care in the state. We would like to request your participation in this evaluation. You may have been directly involved with this program, or you may have no knowledge of this program. In either case, your participation will be helpful in assessing how effective this program was, and to seek ways to improve programs like this in the future. We thank you for all the support that you have provided to us as a team. We want to assure you that information gathered will not be attributed to an individual or a team (unless we ask for permission to quote you).

- *We also would like to take photos of our meetings for our reports-is this OK?*
- *Do we have your permission to begin this interview?*
- *There is no remuneration provided for your participation, but if you become uncomfortable at any time, you may request that we stop the interview, or you are welcome to withdraw from the group.*
- *Do you have any questions before we start?*

INTERVIEW DATA			
Facilitator	**Note taker**	**Date of Interview**	**Recording #**
State	**LGA**	**Ward**	**Village**

PARTICIPANT INFORMATION		
Name of Interviewee_____ **Or:** **Positions of Participants represented at the interview:** Total Number of Participants: _____ M: F:	**Interview Tape Recorded (Please check)** Yes_____ No_____	**Informed consent agreement:** **Yes:**_____ **No:**_____

Codes for questions and IRs	*Introduction: "I am going to be asking about your experience with Saving Mothers Giving Life Initiative (SMGL) on, maternal and newborn health, and other related activities"* .	**Comments**
Background	1. Can you describe your role (PPMV, TBA, & CHV) in relation to the SMGL Project? Probe for: a. Who in the community do you engage with? • Ward Development committees? • Community leaders • Groups of women?	

	• Groups of men? • Individual households • Individual men and women b. Is this work paid or voluntary?	
	2. Please describe the work you do with: • Ward Development committees? • Community leaders • Groups of women? • Groups of men? • Individual households • Individual men and women a. How often do you engage with community members in this role (monthly, quarterly, annually, bi-annual etc)?	
EQ 3; EQ 5	3. What type of support have you received for the work you do from others in the community, health centre, CBOs or others? Probe for: a. Training (ask what the training was on) b. Supervision c. Mentoring/Coaching d. Assistance with health Messages e. Referrals (ETS)	
	13. Which organizations have provided this support? • CBOs (name the CBO) • SMOH personnel • WDCs • PHC Coordinators • Heads of Healthcare and Delivery Facilities • Other	Specify the nature of the support.
	14. What has been the effect of your role in the community on improving health for pregnant women, newborn babies, and new mothers? Prompt: In what ways has your role on the SMGL project has contributed to the increase in demand for: • ANC/ PMTCT • Labour and delivery care • Post-partum care • FP	
	15. What are the most notable changes that have reduced the 3 delays in getting maternal and neonatal healthcare (e.g. the decision to seek care, the delay in getting to the facility, and the delay once at the facility)?	
	16. What have been the most notable changes in how different people and groups act or behave regarding use of maternal and neonatal healthcare services in: • Women's behaviour (of different ages) • Men's behaviour (of different ages)	

	• Community Leaders' behaviour • Religious leaders • Bus, taxi, truck, motor scooter, and other drivers • Healthcare providers	
	17. Which of your activities do you think have contributed to these changes?	
	18. What have been the biggest challenges or barriers in changing behaviour and practice for use of: • ANC • Labour and Health Delivery Service • Post- partum • FP • Newborn care	
	19. What have been the most important changes in relationships among stakeholders that have facilitated uptake of services? Who were the key actors and facilitators of building these relationships?	
	20. What would you want to see done differently that has the potential to increase access to quality FP, labour and health delivery Service?	
	21. Can you describe your ability to continue the current role on the SMGL project at the exit of the project? Are you able to continue without SMGL's support?	
	22. Any other information you want to share for improving programming and delivery of similar project.	

Thank you for sharing your thoughts and opinions with us today. We greatly appreciate the time you took to speak to us

TOOL 05 – INTERVIEW GUIDE FOR SMGL WARD DEVELOPMENT COMMITTEES (WDC)

Informed Consent Paragraph

USAID has requested that GHPRO, a US-based consulting firm conduct a final evaluation of Saving Mothers Giving Life activities in Cross River State during the last five years. As members of the GHPRO team, we are interested in learning about the project and how it has affected access and utilization of maternal and neonatal health care in the state. We would like to request your participation in this evaluation. You may have been directly involved with this program, or you may have no knowledge of this program. In either case, your participation will be helpful in assessing how effective this program was, and to seek ways to improve programs like this in the future. We thank you for all the support that you have provided to us as a team. We want to assure you that information gathered will not be attributed to an individual or a team (unless we ask for permission to quote you).

- *We also would like to take photos of our meetings for our reports-is this OK?*
- *Do we have your permission to begin this interview?*
- *There is no remuneration provided for your participation, but if you become uncomfortable at any time, you may request that we stop the interview, or you are welcome to withdraw from the group.*
- *Do you have any questions before we start?*

INTERVIEW DATA			
Facilitator	**Note taker**	**Date of Interview**	**Recording #**
State	**LGA**	**Ward**	**Village**

PARTICIPANT INFORMATION		
Name of Interviewee_____ **or** **Number and Type of Participants Interviewed** **Positions of Participants represented at the interview:** Total Number of Participants: _____ M: F:	**Interview Tape Recorded (Please check)** Yes_____ No_____	**Informed consent agreement:** **Yes:** _____ **No:** _____

Codes for questions and IRs	*Introduction: "I am going to be asking about your engagement with Saving Mothers Giving Life Initiative SMGL on maternal and newborn health, and other related activities"* *Probe for the term they use for SMGL and how it is referred to by the people they work with.*	**Comments**
Background	1. Please describe the role of your WDC on the SMGL Initiative?	

	a. Who makes up the WDC? (# of men, # of women) b. What are their different roles/positions on the WDC? c. How would you describe your relationship or partnership with SMGL?	
EQ 4; EQ 5b	2. What are the specific supports you received from SMGL? Probe for: f. Training g. Community engagement and SMART advocacy h. Management of ETS drivers i. Fund raising within the communities, government and other partners for the sustenance of the scheme. j. Administrative, technical, or financial,	
EQ4	3. How does the WDC interact with the community groups on issues related to maternal and newborn health? g. Advocacy visits h. Coordination i. Meetings j. Training k. Vouchers l. Media outreach m. Outreach to households n. Oversight/supervision/monitoring of the healthcare facilities?	
EQ4	4. What are the specific supports the WDC provides to the community groups on reducing the delays women experience in reaching and using maternal and newborn health services? a. ETS coordination and management b. Referral of pregnant women to health care facilities c. Others…	
EQ4	5. What are the key community groups that you provide support to improve women's access to ANC, delivery, post-partum and newborn health services? • VDC/WFP • ETS Drivers • Community leaders • Government actors (State and Local) • Others (specify)	
EQ3	6. How frequently do you interact with women and men, and other community groups to support reductions in delays in reaching and using maternal and newborn health services?	

EQ1	7. Can you describe how your role on the SMGL project has contributed to the increase in demand for: • ETS services • ANC/ PMTCT • Labour and delivery care • Post-partum care • FP	
EQ3	8. What have been the most notable changes regarding people's use of maternal and neonatal healthcare services in: • Women's actions, beliefs, and practices • Men's actions, beliefs, and practices • Community Leaders' actions, beliefs, and practices • TBAs' actions, beliefs, and practices • WDC members actions, beliefs, and practices • Transport Drivers' actions, beliefs, and practices • Healthcare Providers' actions, beliefs, and practices • Religious leaders' actions, beliefs, and practices • Other community leaders' actions, beliefs, and practices	
EQ1, EQ4	9. Which of your activities do you think have contributed to these changes in women's access to maternal and newborn health services?	
EQ4	10. What are the major challenges you have in the course of delivering your work? How would you confront these challenges?	
EQ4	11. What would you want to see done differently that has the potential to increase access to quality FP, labour and health delivery Service?	
EQ4	12. Can you describe your ability to continue the current role on the SMGL project at the exit of the project? Are you able to continue without SMGL's support? Are the community ready to take ownership of the scheme and continue? What challenges do you envisage in continuing your role with SMGL's support?	
EQ4	13. Is there any other information you want to share for improving programming and delivery of similar project?	

Thank you for sharing your thoughts and opinions with us today. We greatly appreciate the time you took to speak to us.

TOOL 06 – INTERVIEW GUIDE FOR SMGL PHC COORDINATORS

Informed Consent Paragraph

USAID has requested that GHPRO, a US-based consulting firm conduct a final evaluation of Saving Mothers Giving Life activities in Cross River State during the last five years. As members of the GHPRO team, we are interested in learning about the project and how it has affected access and utilization of maternal and neonatal health care in the state. We would like to request your participation in this evaluation. You may have been directly involved with this program, or you may have no knowledge of this program. In either case, your participation will be helpful in assessing how effective this program was, and to seek ways to improve programs like this in the future. We thank you for all the support that you have provided to us as a team. We want to assure you that information gathered will not be attributed to an individual or a team (unless we ask for permission to quote you).

- *We also would like to take photos of our meetings for our reports-is this OK?*
- *Do we have your permission to begin this interview?*
- *There is no remuneration provided for your participation, but if you become uncomfortable at any time, you may request that we stop the interview, or you are welcome to withdraw from the group.*
- *Do you have any questions before we start?*

INTERVIEW DATA			
Facilitator	**Note taker**	**Date of Interview**	**Recording #**
State	**LGA**	**Ward**	**Village**

PARTICIPANT INFORMATION		
Name of Interviewee: **Position(s) of Interviewee:** Total Number of Other Participants: _____ M: F:	**Interview Tape Recorded (Please check)** Yes_____ No_____	**Informed consent agreement:** **Yes:**_____ **No:**_____

Codes for questions and IRs	Introduction: "I am going to be asking about your engagement with Saving Mothers Giving Life Initiative SMGL on maternal and newborn health, and other related activities" Probe for the term they use for SMGL and how it is referred to by the people they work with.	**Comments**
EQ4; IR 4	1. How will you describe the role of your organization (PHC) on the SMGL Project?	
	2. In the communities that are served by your PHC, what are the **factors that contribute to delays in:** • Pregnant women deciding to attend ANC services and to deliver in the PHC?	

	• Pregnant women reaching the PHC after they have decided to come? • Pregnant women receiving the care they need once they reach the PHC?	
EQs4; IR 4	3. What are the specific supports that you received from SMGL to reduce these delays, especially the third delay once women arrive at the health facility? Probe for: a. Strengthen PHC capacities to have skilled pool of trainers b. Strengthen data collection system c. Strengthen the use of data d. Using data for making informed decisions at LGs	
	4. Who are the key stakeholders that support these activities? • CBOs • NISONM • SOGON etc • HelloMama • SMGL personnel/staff • Others (e.g. FMOH, PHCA)	
	5. How does the PHC interact with community groups? • Meetings • Coordination • Training • Advocacy • Media Outreach • Outreach to households or men's and women's groups	
Additional questions	6. How frequently does the PHC interact with community groups in a specific place in one year? • Ward Development committees? • Community leaders • Groups of women? • Groups of men? • Individual households • Individual men and women	
	7. Please describe how frequently the PHC now collects, reports, and uses data to increase the demand for: • ANC/ PMTCT • Labor and delivery care • Post-partum care • Newborn care • FP	
	8. What are the most significant changes that have contributed to reductions in the: • First Delay (the decision to seek care)? • Second Delay (getting to the healthcare)?	

	• Third Delay (receiving quality care once the woman arrives at the healthcare facility)?	
	9. What have been the most notable changes in behaviour in relation to maternal and neonatal healthcare: • Women's behaviour • Men's behaviour • Community Leaders' behaviour • Religious leaders' behaviour • Transport drivers' behaviour • TBAs behaviour and relationships PHCVendors behaviour • Healthcare providers	
	10. Which of PHC's activities do you think have contributed to these changes?	
	11. What have been the (your) biggest challenge or barriers in relation to SMGL project in changing behaviour and practice for use of: • ANC • Labour and Delivery • Post- partum • FP • Newborn care	
	12. What have been the most important changes in relationships among stakeholders that have facilitated uptake of services? Who were the key actors and facilitators of building these relationships?	
	13. What would you want to see done differently to increase the demand and practice in the following? • ANC • Labour and Delivery • Post- partum • FP • Newborn care	
	14. Any other information you would like to share?	

Thank you for sharing your thoughts and opinions with us today. We greatly appreciate the time you took to speak to us.

TOOL 07 - INTERVIEW GUIDE FOR STATE HEALTH COMMISSIONER / STATE RH COORDINATOR/ CRS PHCDA DIRECTOR

USAID has requested that GHPRO, a US-based consulting firm conduct a final evaluation of Saving Mothers Giving Life activities in Cross River State during the last five years. As members of the GHPRO team, we are interested in learning about the project and how it has affected access and utilization of maternal and neonatal health care in the state. We would like to request your participation in this evaluation. You may have been directly involved with this program, or you may have no knowledge of this program. In either case, your participation will be helpful in assessing how effective this program was, and to seek ways to improve programs like this in the future. We thank you for all the support that you have provided to us as a team. We want to assure you that information gathered will not be attributed to an individual or a team (unless we ask for permission to quote you).

- **Do we have your permission to begin this interview?**
- *There is no remuneration provided for your participation, but if you become uncomfortable at any time, you may request that we stop the interview, or you are welcome to withdraw from the group.*
- *Do you have any questions before we start?*

INTERVIEW DATA			
Facilitator	**Note taker**	**Date of Interview**	**Recording #**
State	**LGA**	**Ward**	**Village**

PARTICIPANT INFORMATION		
Number and Type of Participants Interviewed **Positions of Participants represented at the interview:** Total Number of Participants_____ M: F:	**Interview Tape Recorded (Please check)** Yes No	**Informed consent agreement:** **Yes:** **No:** **Consent for photos:** **Yes: No:**

Codes for questions		**Comments**
	1. Please tell me about your position and for how long have you been in this post 2. How the SMGL has engaged with your office?	
EQ1	3. How effective was the partnership with SMGL? • What worked well? • What is still needed? • How the collaboration/technical assistance between your office and SMGL has strengthened the capacity of health facilities? • Which best practices/lessons learned/success stories could you report about this partnership? • In your opinion, which areas/activities of SMGL have been the most critical to enable the project achievements? • In addition, which areas/activities were less considered by the project that could have had great impact?	

	4. What were the major weaknesses in the health system that the project has addressed? 5. Which areas of the health system has SMGL been most successful in strengthening? Why? 6. Which areas of the health system has SMGL been least successful in strengthening? Why?	
EQ2	7. How the RMNCH interventions selected by SMGL, were aligned with the national reproductive health strategy? a. How those interventions will be maintained or expanded in the health facilities? b. What policy changes did SMGL influence and support? 8. How the way SMGL was implemented, have influenced the service delivery in the targeted health facilities? a. How the project has targeted and addressed the 3-delays? 9. How the participants have benefited from the intervention implemented by SMGL? 10. What were the most significant changes have you seen in the quality of care due to SMGL presence, especially related to EmONC systems and services? *Probe for:* *i. Trainings of health providers* *1. Data analysis and interpretation* *2. Utilization of the HFs (SBA, EmONC)* *3. Medical supply and drugs availability* *4. Deployment of medical volunteers* *5. Coordination capacity and linkages* *6. Referral system (ETS) included the three delays model* *7. Community mobilization* 11. How do SMGL differ from other RHMNCH programs in Nigeria (MCSP, MNCH2, etc.)? a. What aspects of SMGL are more or less effective than other types of interventions? 12. How have you used the data generated by the project to improve the quality of care in the targeted HFs?	
EQ4	13. In your opinion, will your office continue to implement SMGL activities and support the health facilities, after the project end? a. How? b. What challenges do you foreseen that will impede you to continue/support the activities of SMGL? 14. How the infrastructures that were rehabilitated/constructed by SMGL will be able to continue the provision of RMNCH care? 15. What linkages have been created by SMGL between public-private and faith-based health facilities? a. How those links will be maintained? 16. How effective is the transition/exit plan implemented by SMGL in order to allow your office to take over its activities, by September 2019?	
Additional questions	17. What would you like to see done differently, in future projects, with regard to your implication/participation in the project? 18. Do you have other information to share with me?	

Thank you for sharing your thoughts and opinions with us today. We greatly appreciate the time you took to speak to us.

TOOL 08 - KII OR GROUP INTERVIEW GUIDE – EMERGENCY TRANSPORT SYSTEM (ETS) – WARD FOCAL PERSON ON WDC/WDC MEMBERS

Informed Consent Paragraph

USAID has requested that GHPRO, a US-based consulting firm conduct a final evaluation of Saving Mothers Giving Life activities in Cross River State during the last five years. As members of the GHPRO team, we are interested in learning about the project and how it has affected access and utilization of maternal and neonatal health care in the state. We would like to request your participation in this evaluation. You may have been directly involved with this program, or you may have no knowledge of this program. In either case, your participation will be helpful in assessing how effective this program was, and to seek ways to improve programs like this in the future. We thank you for all the support that you have provided to us as a team. We want to assure you that information gathered will not be attributed to an individual or a team (unless we ask for permission to quote you).

- *We also would like to take photos of our meetings for our reports-is this OK?*
- *Do we have your permission to begin this interview?*
- *There is no remuneration provided for your participation, but if you become uncomfortable at any time, you may request that we stop the interview, or you are welcome to withdraw from the group.*
- *Do you have any questions before we start?*

INTERVIEW DATA			
Facilitator	**Note taker**	**Date of Interview**	**Recording #**
State	**LGA**	**Ward**	**Village**

PARTICIPANT INFORMATION		
Name of Interviewee: **Position(s) of Interviewee:** Total Number of Other Participants: _____ M: F:	**Interview Tape Recorded (Please check)** Yes_____ No_____	**Informed consent agreement:** **Yes:**_____ **No:**_____

CODES FOR QUESTIONS AND IRS	**QUESTIONS**	**COMMENTS**
EQ4	*Introduction: "I am going to be asking about your engagement with Saving Mothers Giving Life Initiative SMGL on maternal and newborn health, and other related activities"* *Probe for the term they use for SMGL and how it is referred to by the people they work with.*	
EQ 4:	1. Tell me briefly about the 'Emergency Transport System – ETS' in CRS? Probe for	

	a. How was the initiative conceived? b. Who are the stakeholders involved? c. How does it benefit pregnant women and their families? d. When was it launched/established? e. How does it operate? – LGA – Community – Ward? f. What is the average fare of a voucher for transporting a pregnant woman to a delivery facility? g. How is the pick – up voucher cashed?	
	2. ETS operation. Can you talk more on the ETS operation? Probe for: a. Timely access to the ETS by pregnant women b. Mode of accessing ETS (Phone lines; Focal persons etc.) c. How do pregnant women and their families know about this service? d. Are the vehicles/Tricycles/Motorcycles/Motorized boat readily available in the communities/wards/villages? Who owns or controls the vehicles? What are their roles in the community?	
	3. Management of the ETS – Lets talk about management of the ETS. How is the ETS initiative managed? Probe for: a. Is the initiative (ETS) registered? If yes, where and who registered it? b. Organizational structure of the initiative (ETS) – Organogram? c. Does the initiative have a central office - State/LGA/Community/Village? d. Who is on the ETS "committee"—how many men? How many women?	
	4. How will you describe utilization of the initiative by the pregnant women? Probe for: a. Who uses the ETS? How often? How many per quarter? b. How did they hear about ETS? (Probe: how do pregnant women and their families know about ETS?) c. Does the ETS serve other medical emergencies apart form the pregnant women in labor?	
	5. How does the ETS contribute to reducing deaths of mother and their babies?	
	6. How is the ETS supported? Who provides the fund? How are these funds replenished?	

	7. How will you describe the challenges faced by the initiative (ETS)? Probe for: a. Administrative challenges b. Technical challenges c. Financial challenges d. Others	
	8. How are you able to manage the challenges you mentioned?	
	9. How has the ETS initiative increase access to healthcare facility for delivery by pregnant women?	
	10. Can you describe the changes that can be attributed to ETS initiative in pregnant women delivering in healthcare facility in? a. Pregnant women's actions, beliefs, and practices? b. Their partners' actions, beliefs, and practices? c. Transport providers' actions, beliefs, and practices? d. Others' actions, beliefs, and practices?	
	11. How have relationships among community members and the health services as a result of ETS? a. Between transport drivers/owners and health care providers b. Between pregnant women and healthcare providers c. Between transport drivers/owners and pregnant d. Others?	

Thank you for sharing your thoughts and opinions with us today. We greatly appreciate the time you took to speak to us.

INTERVIEW GUIDE FOR HEAD OF HEALTH FACILITIES – HEADS OF HEALTH FACILITIES UNITS (MNCH-related services)

USAID has requested that GHPRO, a US-based consulting firm conduct a final evaluation of Saving Mothers Giving Life activities in Cross River State during the last five years. As members of the GHPRO team, we are interested in learning about the project and how it has affected access and utilization of maternal and neonatal health care in the state. We would like to request your participation in this evaluation. You may have been directly involved with this program, or you may have no knowledge of this program. In either case, your participation will be helpful in assessing how effective this program was, and to seek ways to improve programs like this in the future. We thank you for all the support that you have provided to us as a team. We want to assure you that information gathered will not be attributed to an individual or a team (unless we ask for permission to quote you).

Do we have your permission to begin this interview?

There is no remuneration provided for your participation, but if you become uncomfortable at any time, you may request that we stop the interview, or you are welcome to withdraw from the group.

Do you have any questions before we start?

INTERVIEW DATA			
Facilitator	**Note taker**	**Date of Interview**	**Recording #**
State	**LGA**	**Ward**	**Village**

PARTICIPANT INFORMATION		
Number and Type of Participants Interviewed **Positions of Participants represented at the interview:** Total Number of Participants____ M____ F____	**Interview Tape Recorded (Please check)** Yes___ No___	**Informed consent agreement:** **Yes:** **No:** **Consent for photos:** **Yes:** **No:**

Codes for questions		**Comments**
	1. Please tell me about your position in this HF and for how long have you been in this post 2. How did SMGL engaged with this health facility?	
EQ1	3. What training/support did you receive from SMGL? a. How the training you have received has helped your work? 4. What contributions has SMGL made to the quality of care for newborns and mothers in your area? a. How any of these contributions are related to the work of the health facility?	

	5. What changes, positive or negative, have occurred in women and newborns' lives as result of access and utilization of the health facilities? 6. Which best practices/lessons learned/success stories could you report concerning the support received by SMGL? a. How will you use them in the future? 7. What is the most significant change have you seen as result of SMGL presence?	
EQ2	*8.* What SMGL interventions were relevant to improve the health service delivery? *Probe for:* *a. Training of the health providers (EmONC, MPDSR, LARC, ENC, PPFP, PAC, etc.)* *b. Deployment of medical volunteers* *c. Collaboration with the Community Health Extension Workers and Traditional Birth Attendants* *d. Support of the Health Management Information System* *e. Medical supply and drugs (including Family Planning)* *f. Emergency Transport System* *g. Community mobilization* *h. EmONC lifesaving innovations* *i. Coordination with local Govt* *j. Rehabilitation of infrastructures* 9. How the supportive supervision you have received, have changed the quality of service delivery in the health facility? 10. How the health facility has addressed the 3-delays model? 11. What linkages has SMGL created between your facility and private or faith-based health facilities? 12. What linkages were created with the local health authorities? 13. How have you been able to work with the Community Volunteers/Traditional Birth Attendants at community-level?	
EQ4	14. How will you maintain the collaboration with the Community Volunteers/Traditional Birth Attendants in the future? 15. What key activities are in place to ensure the health facility will continue to provide health services to the communities? 16. How the linkages created with the private or faith-based facilities will be maintained, after the project end? 17. How SMGL informed the health facility concerning its transition/exit plan?	
Additional questions	18. What would you like to see done differently in future projects with regard to the training, health facility support (medical equipment, infrastructures) and capacity building you have received from SMGL?	

Thank you for sharing your thoughts and opinions with us today. We greatly appreciate the time you took to speak to us.

TOOL 10 - INTERVIEW GUIDE FOR SMGL MEDICAL SOCIETIES OGON-NISOMN-AGPMPN-MENTOR MIDWIVES

Informed Consent Paragraph

USAID has requested that GHPRO, a US-based consulting firm conduct a final evaluation of Saving Mothers Giving Life activities in Cross River State during the last five years. As members of the GHPRO team, we are interested in learning about the project and how it has affected access and utilization of maternal and neonatal health care in the state. We would like to request your participation in this evaluation. You may have been directly involved with this program, or you may have no knowledge of this program. In either case, your participation will be helpful in assessing how effective this program was, and to seek ways to improve programs like this in the future. We thank you for all the support that you have provided to us as a team. We want to assure you that information gathered will not be attributed to an individual or a team (unless we ask for permission to quote you).

- *Do we have your permission to begin this interview?*
- *There is no remuneration provided for your participation, but if you become uncomfortable at any time, you may request that we stop the interview, or you are welcome to withdraw from the group.*
- *Do you have any questions before we start?*

INTERVIEW DATA			
Facilitator	**Note taker**	**Date of Interview**	**Recording #**
State	**LGA**	**Ward**	**Village**

PARTICIPANT INFORMATION		
Number and Type of Participants Interviewed **Positions of Participants represented at the interview:** Total Number of Participants: M:_____ F:_____	**Interview Tape Recorded (Please check)** Yes___ No___	**Informed consent agreement:** **Yes:**___ **No:**____ **Consent for photos:** **Yes:** **No:**

Codes for questions		**Comments**
	1. Please tell me about your position and for how long have you been in this post 2. How the SMGL has engaged with your office?	
EQ1	3. How effective was the partnership with SMGL in order to mentor health providers and deploy medical volunteers in the health facilities targeted by SMGL program? • What worked well? • What is still needed? • How the collaboration/technical assistance between you and SMGL has strengthened the capacity of health providers? • Which best practices/lessons learned/success stories could you report about this partnership? • How will you use them in the future?	

	• In your opinion, which areas/activities of SMGL have been the most critical to enable the project achievements? *Probe for addressing the 3-delays model* • In addition, which areas/activities were less considered by the project that could have had great impact? 4. What challenges did you encountered during the mentorship, the supportive supervision and to deploy, to retain medical volunteers/midwives in remote areas of Cross River State (CRS) 5. What have you and other involved parties done, to address these challenges?	
EQ2	6. How the supportive supervision you have provided have changed the quality of service delivery in SMGL health facilities? 7. How the RMNCH interventions selected by SMGL, were aligned with the national Reproductive Health strategy? c. How those interventions changed the service provision in the selected HFs? d. What policy changes did SMGL influence and support? 8. What has been the mechanism of coordination with SMGL prime? 9. How the placement of medical volunteers have influenced the performance of the SMGL supported health facilities in CRS in term of service delivery? Please explain. a. How have these volunteers increased the medical knowledge, skills and quality of care of the health providers during the mentorship? *(Probe for: the transfer of knowledge and skills to health facility staff; assistance in bridging temporary staffing gaps; encouraging volunteers to consider relocation in CRS rural HFs; establishing a long-term partnership between Nigeria medical societies and State health authorities)* 10. What actions will be taken (or have been taken so far) to maintain the mentorship scheme? 11. What is the Mentorship App? a. How it works? b. What is needed in term of improving this App? 12. How the Maternal Perinatal Deaths Surveillance Response (MPDSR) data were institutionalized in the private health facilities?	
EQ4	13. In your opinion, how you and the CRS health office will continue to support the deployment of medical volunteers and the supportive supervision of the health facility, after SMGL end?	
Additional questions	14. What would you like to see done differently, in future projects, with regard to the training, the mentorship and the supervision you have provided? 15. Do you have other information to share with me?	

Thank you for sharing your thoughts and opinions with us today. We greatly appreciate the time you took to speak to us.

TOOL 11 - INTERVIEW GUIDE FOR RMNCH CORE TECHNICAL COMMITTEE / MATERNAL DEATH REVIEW COMMITTEE

Informed Consent Paragraph

USAID has requested that GHPRO, a US-based consulting firm conduct a final evaluation of Saving Mothers Giving Life activities in Cross River State during the last five years. As members of the GHPRO team, we are interested in learning about the project and how it has affected access and utilization of maternal and neonatal health care in the state. We would like to request your participation in this evaluation. You may have been directly involved with this program, or you may have no knowledge of this program. In either case, your participation will be helpful in assessing how effective this program was, and to seek ways to improve programs like this in the future. We thank you for all the support that you have provided to us as a team. We want to assure you that information gathered will not be attributed to an individual or a team (unless we ask for permission to quote you).
Do we have your permission to begin this interview?

There is no remuneration provided for your participation, but if you become uncomfortable at any time, you may request that we stop the interview, or you are welcome to withdraw from the group.

Do you have any questions before we start?

INTERVIEW DATA			
Facilitator	**Note taker**	**Date of Interview**	**Recording #**
State	**LGA**	**Ward**	**Village**

PARTICIPANT INFORMATION		
Number and Type of Participants Interviewed **Positions of Participants represented at the interview:** Total Number of Participants:_____ M: F:	**Interview Tape Recorded (Please check)** Yes No	**Informed consent agreement:** **Yes:** **No:** **Consent for photos:** **Yes:** **No:**

Codes for questions		**Comments**
	1. Please tell me how long ago this committee was created and for how long have you been into it 2. What is role and responsibilities of the committee	
EQ1	3. What support have you received from SMGL? 4. How this support has enabled you to perform? 5. What were the pivotal activities/relationships promoted by SMGL, have enabled your work? 6. How the project has supported the committee in recognize and addressing the 3-delays? 7. Which best practices/lessons learned/success stories could you report concerning the support received by SMGL? a. How will you use them in the future?	

	MPDSR Committee: 8. What challenges have you encountered in gathering and using the maternal and neonatal mortality data? 9. What was the most significant change have you seen as results of the mortality data reporting and audits? **RMNCH committee:** 10. How has the support received from SMGL strengthened the RH coordination? 11. What challenges have you encountered to coordinate the RH actors? 12. What was the most significant change have you seen as results of the coordination enterprise by the committee?	
EQ2	**MPDSR Committee:** *13*. How have you used the mortality data gathered from the health facilities? *Probe for:* *a. Map trends on maternal and perinatal deaths* *b. Inform local, central Govt and HFs* *c. Data audit* *d. Recognize and addressing 3-delays* 14. What corrective measures have the committee backed-up in case of an increase of maternal and perinatal deaths in BEmONC and CEmONC facilities?	
EQ4	15. What mechanisms are in place to enable this committee to continue its role? a. What is still missing?	
Additional questions	16. Do you have other information to share with me?	

Thank you for sharing your thoughts and opinions with us today. We greatly appreciate the time you took to speak to us.

TOOL 12 - INTERVIEW GUIDE FOR SMGL PROJECT MANAGER - TECHNICAL MANAGERS ABUJA AND CALABAR

Informed Consent Paragraph

USAID has requested that GHPRO, a US-based consulting firm conduct a final evaluation of Saving Mothers Giving Life activities in Cross River State during the last five years. As members of the GHPRO team, we are interested in learning about the project and how it has affected access and utilization of maternal and neonatal health care in the state. We would like to request your participation in this evaluation. You may have been directly involved with this program, or you may have no knowledge of this program. In either case, your participation will be helpful in assessing how effective this program was, and to seek ways to improve programs like this in the future. We thank you for all the support that you have provided to us as a team. We want to assure you that information gathered will not be attributed to an individual or a team (unless we ask for permission to quote you).

- *Do we have your permission to begin this interview?*
- *There is no remuneration provided for your participation, but if you become uncomfortable at any time, you may request that we stop the interview, or you are welcome to withdraw from the group.*
- *Do you have any questions before we start?*

INTERVIEW DATA			
Facilitator	**Note taker**	**Date of Interview**	**Recording #**
State	**LGA**	**Ward**	**Village**

PARTICIPANT INFORMATION		
Number and Type of Participants Interviewed **Positions of Participants represented at the interview:** Total Number of Participants_____ M: F:	**Interview Tape Recorded (Please check)** Yes No	**Informed consent agreement:** **Yes:** **No:** **Consent for photos:** **Yes:** **No:**

Codes for questions		**Comments**
	1. Please tell me about your position in this program and for how long have you been in this post	
EQ1	2. How has the TA provided by SMGL enabled the local Govt, the HFs and the health providers (public, private and faith-based) to adopt and use RMNCH interventions? 3. What contributions has SMGL made to: a. the quality of care for newborns and mothers b. the utilization and access of RMNCH services	

	c. Recognize and address the 3-delays 4. Which best practices/lessons learned/success stories could you report on SMGL? 5. How was the program managed that led to unforeseen problems or benefits? 6. What are the major weaknesses in the health system that the project has addressed? Which areas of the health system has SMGL been most successful in strengthening? Why? 7. Which areas of the health system has SMGL been least successful in strengthening? Why? *8.* What major challenges have you encountered during the implementation of SMGL that have affected the project performance (*low target achievements, staff turnover, collaboration with local Govt, etc.)* 9. How critical was the support received by USAID to implement the project? a. Was this support sufficient? b. What suggestion/consideration would you made about it?	
EQ2	10. How the way SMGL was implemented, have influenced the service delivery in the targeted HFs? 11. How the RMNCH interventions selected by SMGL, were aligned with the national RH strategy? e. How those interventions will be maintained or expanded in the health facilities? f. What policy changes did SMGL influence and support? 12. How have the project participants benefited from the interventions implemented by SMGL? 13. What were the most significant changes as result of SMGL implementation? 14. Were there other organizations (local, international, private, etc.) working in the same communities/health facilities with similar projects than SMGL? c. If *YES*, what mechanism of coordination was in place? 15. What has been the mechanism of coordination within the SMGL partners? (*Probe for: M4M, HelloMAMA, local Govt, medical societies*) 16. How do SMGL differ from other RHMNCH programs in Nigeria (MCSP, MNCH2, etc.)? a. What aspects of SMGL are more or less effective than other types of interventions? 17. How have you used the data generated by the project to: a. improve the quality of care b. strength the capacity of the health providers c. strength logistics system (medical supply and drugs) d. capture access and utilization of the health facilities e. Recognize and address the 3-delays	

EQ4	18. SMGL have invested in the creation of linkages between private and faith-based health service providers. How will these linkages continue? 19. What systems/structures are in place to guarantee continuation of the SMGL activities? 20. What transition/exit plan is SMGL implementing in order to allow the local Govt to take over its activities, by September 2019?	
Additional questions	21. What would you like to see done differently, in future projects, with regard the activities SMGL has provided? 22. Do you have other information to share with me?	

Thank you for sharing your thoughts and opinions with us today. We greatly appreciate the time you took to speak to us.

TOOL 13 - MOST SIGNIFICANT CHANGE GUIDE FOR WOMEN AND MEN IN SMGL INTERVENTION COMMUNITIES

Informed Consent Paragraph

USAID has requested that GHPRO, a US-based consulting firm conduct a final evaluation of Saving Mothers Giving Life activities in Cross River State during the last five years. As members of the GHPRO team, we are interested in learning about the project and how it has affected access and utilization of maternal and neonatal health care in the state. We would like to request your participation in this evaluation. You may have been directly involved with this program, or you may have no knowledge of this program. In either case, your participation will be helpful in assessing how effective this program was, and to seek ways to improve programs like this in the future. We thank you for all the support that you have provided to us as a team. We want to assure you that information gathered will not be attributed to an individual or a team (unless we ask for permission to quote you).

- *We also would like to take photos of our meetings for our reports-is this OK?*
- *Do we have your permission to begin this interview?*
- *There is no remuneration provided for your participation, but if you become uncomfortable at any time, you may request that we stop the interview, or you are welcome to withdraw from the group.*
- *Do you have any questions before we start?*

Most Significant Change Question: In the last 2 years, what do you think is the most significant (i.e. most important) change that has occurred in women's and men's roles, responsibilities, or relationships in the household and community with regard to pregnancy and childbirth as a result of the SMGL project?

MSC Instructions for Facilitators:

Have participants form even numbered groups so that they can break into pairs. Preferably do not make the groups larger than 6-8. Provide them with paper and pens/pencils or markers for drawing or writing.

Discuss with them the objective of what they are going to do. We are going to explore changes that have occurred in this community during the last 2-3 years as a consequence of the SMGL project.

By change we mean a difference in how someone acts or behaves compared to how they acted or behaved at an earlier point in time. For the first delay, it can also mean a change in a routine task or decision that a woman can do or make now that she could not do or make in the past. I could also be a change in actions or tasks that men engage in now that they did not do in the past. For instance, if before men rarely cooked food and now they cook food more regularly, or if women never cultivated_____(insert a crop that is usually planted by men), and now they do. We want to understand these changes in relation to behavior, actions, practices, and decisions during pregnancy and childbirth.

We would like you to tell us about these changes, good or bad, that have occurred by telling us stories about real women's and men's experiences. They can be about anyone in the community: a pregnant woman, her husband, a family member, a community leader, a health worker, TBA, ETS driver, or anyone else, whose story shows a change as a result of the project.

Facilitator says: Please draw (or write) a story about someone or a group of people who illustrate change in response to the question:

> *In the last 2 years, what do you think is the most significant (i.e. most important) change that has occurred in women's and men's roles, responsibilities, or relationships in the household and community with regard to pregnancy and childbirth as a result of the SMGL project? Please write a story about a real person or group of persons that illustrates the significant change.*

Make sure to include information about the person, the situation she or he found herself/himself in, the change that took place, and why you think this change is important. A good story (about 10 minutes). A good story describes:

- What the change is?
- Who it happened to?
- What happened to bring about the change?

Make sure that you also provide background information on who collected and told the story, where, and about the events that the story refers to. Finally, be specific about why you think the change is significant.

Facilitators should take detailed notes on all discussions within the groups, especially those that take place about why one story was selected over the others.

Make sure to include information about the person, the situation she or he found herself/himself in, the change that took place, and why you think this change is important. A good story (about 10 minutes). A good story describes:

- What the change is?
- Who it happened to?
- What happened to bring about the change?

Make sure that you also provide background information on who collected and told the story, where, and about the events that the story refers to. Finally, be specific about why you think the change is significant.

After drawing your story, please tell the story to your partner and then listen to his/her story (about 15 minutes).

Facilitator: Once you have shared the stories in pairs, please share each story within your small group (whole group of 6-8 persons --30 minutes).

Ask the group to select the story or stories (1, or 2) that illustrate the most significant change (the change that was most significant among all the stories that were told).

They can make the decision any way they choose --by consensus, voice vote, secret vote, or by assigning points to each story. It is up to the group how they decide. The facilitator should take detailed notes on the discussion (about 15-20 minutes).

After they have selected the stories in the small group, bring the small groups together into a larger group.

and have each group read or tell the story they have selected as the most significant change to the larger group. Have each presenter summarize why the small group thought the story they presented was most significant.

After they have finished hearing the MSC story from each group, ask them whether there were some common changes that occurred in the different stories told in the small groups (all the stories not just those selected) and what those changes were about (themes). Write them on a flipchart. Then ask if the MSC stories fall across those themes or not.

After all the stories have been read, the large group should again decide how they are going to select the most significant change among all the stories—e.g., by voice vote, consensus discussion, secret vote, or assignment of points. Ask the large group to select the one story out all the stories from the small groups that is most significant. Ask them if they were to share this story with others in their community, they would agree that it was a significant change.

Thank all participants for the participation and tell them that the stories will help USAID and Pathfinder understand better the affects of SMGL on their communities and especially on pregnant women and their babies.

TOOL 14 - MOST SIGNIFICANT CHANGE GUIDE FOR SMGL STAFF OR HOSPITAL STAFF

Informed Consent Paragraph

USAID has requested that GHPRO, a US-based consulting firm conduct a final evaluation of Saving Mothers Giving Life activities in Cross River State during the last five years. As members of the GHPRO team, we are interested in learning about the project and how it has affected access and utilization of maternal and neonatal health care in the state. We would like to request your participation in this evaluation. You may have been directly involved with this program, or you may have no knowledge of this program. In either case, your participation will be helpful in assessing how effective this program was, and to seek ways to improve programs like this in the future. We thank you for all the support that you have provided to us as a team. We want to assure you that information gathered will not be attributed to an individual or a team (unless we ask for permission to quote you).

- *We also would like to take photos of our meetings for our reports-is this OK?*
- *Do we have your permission to begin this interview?*
- *There is no remuneration provided for your participation, but if you become uncomfortable at any time, you may request that we stop the interview, or you are welcome to withdraw from the group.*
- *Do you have any questions before we star*

Most Significant Change Question: In the last 2 years, what do you think is the most significant (i.e. most important) change that has contributed to the reducing or increasing one of the 3 delays that women experience in accessing and using maternal, neonatal, and reproductive health services?

MSC Instructions for Facilitators:

Have participants form even numbered groups so that they can break into pairs. Preferably do not make the groups larger than 6-8. Provide them with paper and pens/pencils or markers for drawing or writing.

Discuss with them the objective of what they are going to do. We are going to explore changes that have occurred in this community during the last 2-3 years as a consequence of the SMGL project.

By change we mean a difference in how someone acts or behaves compared to how they acted or behaved at an earlier point in time that has either enabled or obstructed access and use of health

services.

- In relation to the first delay, It can also mean a change in a routine task or decision that a man made in the past, that a woman now can do or decide, or a change in a task that a pregnant woman did in the past that a man now can do. For instance, if before men rarely cooked food and now they do more regularly, or if women never cultivated_____(insert a crop that is usually planted by men), and now they do. We want to understand these changes in relation to behavior, actions, practices, and decisions during pregnancy and childbirth.
- For the second delay, it can be any action taken by an person (man or woman) or a group that facilitates or impedes women's access to facilities once they have decided to seek care.

- For the third delay, the change can be any change in action or task by a man or woman at the health facility, or relationships among healthcare workers or between healthcare workers and pregnant women or their companions at the health facility that affects the quality of care.

We would like you to tell us about these changes, good or bad, that have occurred by telling us stories about real women's and men's experiences. They can be about anyone in the community: a pregnant woman, her husband, a family member, a community leader, a health worker, TBA, ETS driver, or anyone else, whose story shows a change as a result of the project.

Facilitator says: Please divide into pairs and each individually write a story about someone or a group of people who illustrate change in response to the question:

> In the last 2 years, what do you think is the most significant (i.e. most important) change that has contributed to reducing or increasing one of the 3 delays that women experience in accessing and using maternal, neonatal, and reproductive health services? Please write a story about a real person or group of persons that illustrates the significant change.

Facilitators should take detailed notes on all discussions within the groups, especially those that take place about why one story was selected over the others.

Make sure to include information about the person, the situation she or he found herself/himself in, the change that took place, and why you think this change is important. A good story (about 10 minutes). A good story describes:

- What the change is?
- Who it happened to?
- What happened to bring about the change?

Make sure that you also provide background information on who collected and told the story, where, and about the events that the story refers to. Finally, be specific about why you think the change is significant.

After writing your story, please tell the story to your partner and then listen to his/her story (about 15 minutes).

Facilitator: Once you have shared the stories in pairs, please share each story within your small group (whole group of 6-8 persons --30 minutes).

Ask the group to select the story or stories (1, or 2) that illustrate the most significant change (the change that was most significant among all the stories that were told).

They can make the decision any way they choose --by consensus, voice vote, secret vote, or by assigning points to each story. It is up to the group how they decide. The facilitator should take detailed notes on the discussion (about 15-20 minutes).

After they have selected the stories in the small group, bring the small groups together into a larger group.

and have each group read or tell the story(ies) they have selected as the most significant change to the larger group. Have each presenter summarize why the small group thought the story they presented was most significant.

After they have finished hearing the MSC story from each group, ask them whether there were some common changes that occurred in the different stories told in the small groups (all the stories not just

those selected) and what those changes were about (themes). Write them on a flipchart. Then ask if the MSC stories fall across those themes or not.

After all the stories have been read, the large group should again decide how they are going to select the most significant change among all the stories—e.g., by voice vote, consensus discussion, secret vote, or assignment of points. Ask the large group to select the one story out all the stories from the small groups that is most significant.

TOOL 15- GUIDE FOR MEL MANAGERS IN PATHFINDER INTERNATIONAL, DEVTECH, STATE AND LGA

Informed Consent Paragraph

USAID has requested that GHPRO, a US-based consulting firm conduct a final evaluation of Saving Mothers Giving Life activities in Cross River State during the last five years. As members of the GHPRO team, we are interested in learning about the project and how it has affected access and utilization of maternal and neonatal health care in the state. We would like to request your participation in this evaluation. You may have been directly involved with this program, or you may have no knowledge of this program. In either case, your participation will be helpful in assessing how effective this program was, and to seek ways to improve programs like this in the future. We thank you for all the support that you have provided to us as a team. We want to assure you that information gathered will not be attributed to an individual or a team (unless we ask for permission to quote you).

- *Do we have your permission to begin this interview?*
- *There is no remuneration provided for your participation, but if you become uncomfortable at any time, you may request that we stop the interview, or you are welcome to withdraw from the group.*
- *Do you have any questions before we start?*

INTERVIEW DATA			
Facilitator	**Note taker**	**Date of Interview**	**Recording #**
State	**LGA**	**Ward**	**Village**

PARTICIPANT INFORMATION		
Number and Type of Participants Interviewed **Positions of Participants represented at the interview:** Total Number of Participants_____ M: F:	**Interview Tape Recorded (Please check)** Yes No	**Informed consent agreement:** **Yes:** **No:** **Consent for photos:** **Yes:** **No:**

Codes for questions		**Comments**
	1. Can you describe your role and responsibilities of your position? • How long have you been in this position? • How long have you been in this position? What was your prior experience in similar work?	
	2. What kind of data do you collect? (generate list of different types of data/indicators) • How is (each type of) data collected? • With what frequency? • From how many facilities/communities/ organizations?	

	1. What guides your M&E data collection, analysis, and reporting system? • PMEL plan • Workplan • DHIS required indicators	
	2. What kind of support does SMGL (or Devtech, LGA, State government, etc) provide to the primary data collectors (e.g health facilities, CBO field officers, community health volunteers, etc) • Data collection and reporting protocols/M&E forms etc (including availability of these forms or tools) • How are data entered and reported at HFs and LGA? Is there any support given? • Data quality guidance • Data use guidance	
	3. What kind of supervision does SMGL (or Devtech, LGA, State government, etc) do of data collection within health facilities? • Frequency and membership of supervision visits? • Implementation of Supervision • Gaps/challenges of doing supervision and ways of overcoming them • Effectiveness of supervision visits in improving data availability, quality and reporting • Gender norms or cultural practices affecting supervision of data collection?	
	4. Who within (e.g. the project, department, office, or facility, etc) uses data for decision making? What data is used? • How does data inform decisions?	
	5. Can you provide an example of an effective use health information or other M&E information that informed an implementation or policy decision? What was the outcome/result? How are staff in M&E positions in HF, LGA, or State MOH selected for positions in M&E? What kind of previous training, education, or previous experience is required? • How many of your current staff are women? How many are men? How many men have been trained? How many women have been trained? • What are your contributions in the area of M&E training materials or aids? • How do you ensure availability of RH providers with M&E experience and skills? • How effective are on the job-training, coaching and mentoring?	
	6. How is data collection and reporting coordinated among different partners across: • The project,	

	• Health facilities?	
	7. The state? What approach or strategy has contributed the most in improving M&E in SMGL project in Cross Rivers state? • What are the lessons learnt from this approach? • What do you see as the major system changes or skills transfer resulting from SMGL in the area of M&E?	
	8. What challenges have you faced in collecting, analyzing, and reporting maternal and neonatal health M&E? How have you overcome these challenges?	
	9. What other challenges are associated with maternal and neonatal health M&E (data collection, entry, analysis and reporting) in this project or state? What are the most effective and feasible ways to address them?	

Thank you for sharing your thoughts and opinions with us today. We greatly appreciate the time you took to speak to us.

TOOL 16 HEALTH FACILITY OBSERVATION CHECKLIST

S/N	Things to Observe/Inquiry	Y	N	Comments
	Monitoring and Evaluation			
1.	Does the HF have registers for maternal and child health programs?			
2.	Does the HF have monthly summary forms (MSF) for maternal and child health programs?			
3.	Do you prepare and submit MSF/reports?			
4.	Do you have access to MIS/data reporting system (DHIS2.0) for monthly data entry?			
	Data Quality			
5.	Are monthly visits on technical assistance, supportive supervision and monitoring for data quality assurance being done by SMGL staff?			

6.	Are the quarterly visits for supportive supervision (SS), and monitoring for data quality being done as scheduled by SMGL staff?			
7.	Is information about the last SS visit available? Does it clearly state findings and actions?			
8.	On review of SS visits, is there evidence that actions were taken?			
9.	Are registers and MSF properly filled and signed?			
	Data Use			
10	Are there related facility progress charts?			
11	Is quarterly review of service delivery data done?			
12	Any evidence of collected data being used for decision making such as improvement of quality of services, procurement etc			
	Staff Development			
13	Are there (relevant) Training modules and teaching aids for step-down training?			
14	Is there a system and format for Staff skills/performance assessments?			
15	Are there records documenting staff training disaggregated by sex?			
	Others			
16	Is there constant supply of commodities and tools?			
17	Are their stock-outs of commodities and tools?			

18	Are there new or revised data tools in the HF?			

***Y = 1**

***N = 2**

General Comments:

ANNEX IV. SOURCES OF INFORMATION

PUBLICATIONS

Koblinsky, Marge, Claudia Morrissey Conlon, Florina Serbanescu (eds) 2019. *Saving Mothers, Giving Life*

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AGCOD July 2017-June 2018.Quarterly Reports

CHEDRES July 2017-July 2018. Quarterly Reports

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Pathfinder International/E2A June 2018. Increasing Access to Family Planning and maternal and Newborn Health Information and Services for Fist-Time Parents in Cross River State: Pre-intervention Qualitative Assessment Report.

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Pathfinder International/SMGL 2016. Nigeria Accessibility to EmONC facilities in the State of Cross River. SMGL Project Report.

Pathfinder International/SMGL 2016-2019. Training Activity Reports

Pathfinder International/SMGL 2016-2019. Training Curriculum (participant and facilitators manuals).

USAID Program Description, September 2014. Saving Mothers, Giving Life (SMGL): Financing Mechanism: Evidence to Action (E2A).

Databases

Pathfinder International/SMGL Project Monitoring Database

MICS

DHIS2

KEY PERSON AND GROUP INTERVIEWS

1. USAID Officials

S/N	Name	Sex	Organization	Position
1	Amobi Andrew Onovo	M	USAID/Nigeria/HPN	Monitoring and Evaluation Specialist
2	Gertrude Odezugo	F	USAID/Nigeria/HPN	Senior Reproductive Health Manager; SMGL Activity Manager
3	Vathani Amirthanayagam	F	USAID/Nigeria/HPN	Acting Reproductive, Maternal, Newborn & Child Health Team Lead
4	Claudia Morrissey Conlon, MD, MPH	F	Formerly USAID/W/GH/MNCH	USAID Senior Maternal and Newborn Health Advisor; USG Lead, Saving Mothers, Giving Life

2. Health Facility Workers

S/N	Name	Sex	Organization	LGA	Position
1	Bassey G. Ojah	F	St Joseph Hospital	Akpabuyo	HNS
2	Asuquo Enouch F	M	St Joseph Hospital	Akpabuyo	Medical Officer
3	Mary U. Utsu	F	St Joseph Hospital	Akpabuyo	CNS/Maternity
4	Effioanwan Etim Obu	F	St Joseph Hospital	Akpabuyo	CNS
5	Bassey O. Etim	F	St Joseph Hospital	Akpabuyo	Coordinator CCRM
6	Dr Offiong Okihr	M	St Joseph Hospital	Akpabuyo	Medical Superintendent
7	Beatrice E. Ekom	F	PHC Idundu	Akpabuyo	CHO
8	Edemanwan O. Ita	F	PHC Idundu	Akpabuyo	PCHEW
9	Francis Okon Ita	M	PHC Idundu	Akpabuyo	CHEW
10	Calister Ola Ogban	M	PHC Idundu	Akpabuyo	H/CHEW

S/N	Name	Sex	Organization	LGA	Position
11	Mary Elemi Ebong	F	PHC Idundu	Akpabuyo	CHEW
12	Edbmi Evetutum Ekponyong	F	PHC Idundu	Akpabuyo	CHEW
13	Christhana Bassey Esslen	F	PHC Idundu	Akpabuyo	PCHEW
14	Catherine John Obeten	F	PHC Idomi	Yakurr	OIC
15	Caroline Okon U	F	PHC Idomi	Yakurr	Mentor midwife
16	Magolallue Ubana Ubi	F	PHC Idomi	Yakurr	CHEW
17	Comfort James Akpama	F	PHC Idomi	Yakurr	CHEW
18	Nkanu Rebecca Ubi	F	PHC Idomi	Yakurr	CHEW
19	Arit Inyang Iboh	F	PHC Mkpani	Yakurr	Mentor Midwife
20	Margaret Usani Ibiang	F	PHC Mkpani	Yakurr	Junior CHEW
21	Hope Uguru Ofem	F	PHC Mkpani	Yakurr	CHEW
22	Mary Obono Eteng	F	PHC Mkpani	Yakurr	CHO
23	David Oyira	M	ANSOR Clinic, Ugep	Yakurr	M&E
24	Mauri Esu Erian	F	ANSOR Clinic, Ugep	Yakurr	Matron
25	Nkoyo Ofem Oka		PHC Ugep	Yakurr	PHCC
26	Joyce Igri Omini		PHC Ugep	Yakurr	Officer i/c
27	Alice Okon Onen		PHC Ugep	Yakurr	Senior Nursing Officer
28	Beatrice Out Ettah		PHC Ugep	Yakurr	Senior CHEW
29	Uket Usang Ferd.		PHC Ugep	Yakurr	CHEW
30	Obia Iwara		PHC Ugep	Yakurr	PCHEW
31	Rachael Simon L		PHC Ugep	Yakurr	Senior CHEW
32	Ijaja obeten Butum		PHC Ugep	Yakurr	CHEW
33	Atu Mary Francis		PHC Ugep	Yakurr	Mentor Midwife
34	Jimmy Magdalene Ibom		PHC Ugep	Yakurr	PHAR. TECH.
35	Gupo Justin Enana	F	PHC, Ikot Omin	Calabar Municipal	Mentor midwife
36	Okon Achghi Archibong	F	PHC, Ikot Omin	Calabar Municipal	Deputy Director
37	Dr Arthur M. Udoh	M	Emmanuel Infirmary	Calabar Municipal	DMS
38	Glory E. Kingeorge	F	Emmanuel Infirmary	Calabar Municipal	Matron
39	Mercy Udoewah	F	Emmanuel Infirmary	Calabar Municipal	Admin
40	Joy A Odu	F	General Hospital, Ogoja	Ogoja	CNS
41	Ada Njagu	F	General Hospital, Ogoja	Ogoja	CNS
42	Theresa Egwom	F	General Hospital, Ogoja	Ogoja	CNS

S/N	Name	Sex	Organization	LGA	Position
43	Juliana Aboh	F	General Hospital, Ogoja	Ogoja	ACNS
44	Abue Janet M	F	General Hospital, Ogoja	Ogoja	DPH
45	Inyambe Philomina	F	General Hospital, Ogoja	Ogoja	PNSI
46	Olom Elizabeth	F	General Hospital, Ogoja	Ogoja	CNS
47	Anoh Lucy Frank	F	General Hospital, Ogoja	Ogoja	CNS
48	Idagu Martina Ichuku	F	General Hospital, Ogoja	Ogoja	NS
49	Agnes N. Okim	F	General Hospital, Ogoja	Ogoja	CNS
50	Janet N. Okpon	F	General Hospital, Ogoja	Ogoja	CNS
51	Veronica Atianzenye	F	Catholic Maternity Hospital, Ogoja	Ogoja	NMW
52	Mgbekem Anna B	F	PHC Ekumtak	Ogoja	CCHO
53	Pius	M	PHC, Ibil	Ogoja	Facility head
54	Achi Bassey A	F	Comprehensive Health Center	Ikom	Deputy Director
55	Rev. Fr. Moses Ndifon	M	Holy Family Catholic Hospital	Ikom	Administrator
56	Dr Okpono Joseph C.	M	Holy Family Catholic Hospital	Ikom	Chairman
57	Joy Awuri	F	PHC, Emangabe	Ikom	CHEW (Rep, Head of facility)
58	Dr Ezenwa Odurukwe	M	Melrose Hosp	Ikom	Med. Doctor
59	Dr Ezeaku Collins	M	Melrose Hosp.	Ikom	Med. Doctor
60	Mr Micamby S. Oyongha	M	Melrose Hosp.	Ikom	Lab.

3. Community-Based Stakeholders

S/N	Name	Sex	Community	LGA	Stakeholder type	Position
1	Asekwa Okon	M	Ikorosipo	Akpabuyo	Com/religious leader	Chief
2	Chief Ekurotu Nelson	M	Nakanda	Akpabuyo	Com/religious leader	Chief
3	Chief Mrs Bassey E. Otu	F	Ikot Nakanda	Akpabuyo	Com/religious leader	Chief (Mrs)
4	Evang. Emmanuel O Ntiero	M	Ikot Nakanda	Akpabuyo	Com/religious leader	Clergy
5	Mont Nzeribe	M	Ikot Nakanda	Akpabuyo	ETS	Chairman
6	Akan Friday	M	Ikot Nakanda	Akpabuyo	ETS	Member

S/N	Name	Sex	Community	LGA	Stakeholder type	Position
7	Okon Midi	M	Ikot Nakanda	Akpabuyo	ETS	Member
8	John E. Etim	M	Ikot Nakanda	Akpabuyo	ETS	Member
9	Etim Effiong John	M	Ikot Nakanda	Akpabuyo	ETS	Secretary
10	Effiong Asuquro Akpan	M	Ikot Nakanda	Akpabuyo	ETS	Driver
11	Okon Asuquo Okon	M	Ikot Nakanda	Akpabuyo	ETS	Driver
12	Okon Joseph Etim	M	PHC Ikot Nankada	Akpabuyo	WDC	Secretary
13	Elder Out Efiom Edet	M	PHC Ikot Nankada	Akpabuyo	WDC	Chairman
14	Dominic Edem Ekpenyeng	M	PHC Ikot Nankada	Akpabuyo	WDC	Vice Chairman
15	Nyong Edem Ekpe	M	PHC Ikot Nankada	Akpabuyo	WDC	PRO
16	Nngne H. Yellowduke	F	PHC Ikot Nankada	Akpabuyo	WFP	CCHEW
17	Aduk Effiong Edem	F	PHC Ikot Nankada	Akpabuyo	WDC	Treasurer
18	Lucia Dominic Okon	F	PHC Ikot Nankada	Akpabuyo	WDC	Assistant Secretary
19	Edem-awan Bassey Edet	F	PHC Ikot Nankada	Akpabuyo	WDC	Ex-Official
20	Apostle Edem Efiong Dan	M	PHC Idundun	Akpabuyo	Spouse/partner	Community Member
21	Glory Edet Mattew	F	PHC Idundun	Akpabuyo	TBA	Community Member
22	Patiase E. Ekefre	F	PHC Idundun	Akpabuyo	TBA	Community Member
23	Happiness Okun Jackson	F	PHC Idundun	Akpabuyo	TBA	Community Member
24	Nsisong Edet Bassey	F	PHC Idundun	Akpabuyo	TBA	Community Member
25	Uduah Ayi	F	PHC Idundun	Akpabuyo	TBA	Community Member
26	Esoanwan Eso Nsa	f	PHC Idundun	Akpabuyo	Older woman	Community Member
27	Esther Oyih Archibong	F	PHC Idundun	Akpabuyo	Older woman	Community Member
28	Comfort Elo	F	PHC Idundun	Akpabuyo	Older woman	Community Member
29	Akanigene Okon Bassey	F	PHC Idundun	Akpabuyo	Older woman	Community Member
30	Asari Adim Nsa	F	PHC Idundun	Akpabuyo	Older woman	Community Member
31	Grace Samuel Okon	F	PHC Idundun	Akpabuyo	Older woman	Community Member

S/N	Name	Sex	Community	LGA	Stakeholder type	Position
32	Comfort Nwuam	F	PHC Idundun	Akpabuyo	Older woman	Community Member
33	Grace Bassey	F	PHC Idundun	Akpabuyo	Older woman	Community Member
34	Nadia Eso Nsa	F	PHC Idundun	Akpabuyo	Older woman	Community Member
35	Akanigene Edem	F	PHC Idundun	Akpabuyo	Older woman	Community Member
36	Nkoyo Okon Bassey	F	PHC Idundun	Akpabuyo	Older woman	Community Member
37	Glory Edet Matthew	F	PHC Idundun	Akpabuyo	New mother	Community Member
38	Patrick E. Ekefre	F	PHC Idundun	Akpabuyo	New mother	Community Member
39	Happiness Okon Jackson	F	PHC Idundun	Akpabuyo	New mother	Community Member
40	Nsisong Edet Bassey	F	PHC Idundun	Akpabuyo	New mother	Community Member
41	Uduak Ayi	F	PHC Idundun	Akpabuyo	New mother	Community Member
42	Peace Emmanuel Ika	F	PHC Idundun	Akpabuyo	New mother	Community Member
43	Ima-Obong Eden Effiong	F	PHC Idundun	Akpabuyo	New mother	Community Member
44	Udeme Sunday Emmanuel	F	PHC Idundun	Akpabuyo	New mother	Community Member
45	Adim Edem Effiom	F	PHC Idundun	Akpabuyo	New mother	Community Member
46	Chidinma Effiom Etim	F	PHC Idundun	Akpabuyo	New mother	Community Member
47	Ibiang Ebindom Okah	M	PHC Idomi	Yakurr	ETS	Chairman
48	Ofem Ubi Ebri	M	PHC Idomi	Yakurr	ETS	Member
49	Mark E Eyong	M	PHC Idomi	Yakurr	ETS	Member
50	Bassey Omini Ubi	M	PHC Idomi	Yakurr	ETS	Member
51	Esom Egom Bassey	M	PHC Idomi	Yakurr	ETS	Member
52	Ofem Eyong	M	PHC Idomi	Yakurr	WDC	Member
53	Eteng O. Eyong	M	PHC Idomi	Yakurr	WDC	Secretary
54	Nicholas B. Ubelum	M	PHC Idomi	Yakurr	WDC	Member
55	Samuel Butum Bam	M	PHC Idomi	Yakurr	WDC	Member
56	Mrs Alice L. Okon	F	PHC Idomi	Yakurr	WDC	Women Leader
57	Nkamu Buthman Eyong	M	PHC Idomi	Yakurr	WDC	Member
58	Ubana Okov Otio	M	Ugep	Yakurr	Spouse/partner	Community Member

S/N	Name	Sex	Community	LGA	Stakeholder type	Position
59	Christian Kanu	M	Ugep	Yakurr	Spouse/partner	Community Member
60	Omini Ubangha M	M	Ugep	Yakurr	Spouse/partner	Community Member
61	Joseph Oyama	M	Ugep	Yakurr	Spouse/partner	Community Member
62	Ikechukwu Egwu	M	Ugep	Yakurr	Spouse/partner	Community Member
63	Ani Prince	M	Ugep	Yakurr	Spouse/partner	Community Member
64	Precious Amaike Christian	F	Ugep	Yakurr	New mother	Community Member
65	Ikechukwu Peace	F	Ugep	Yakurr	New mother	Community Member
66	Happiness Ubana	F	Ugep	Yakurr	New mother	Community Member
67	Comfort Joseph Oyama	F	Ugep	Yakurr	New mother	Community Member
68	Nkechi Prince	F	Ugep	Yakurr	New mother	Community Member
69	Shevil Ubanga	F	Ugep	Yakurr	New mother	Community Member
70	Blessing Solomon	F	Ugep	Yakurr	New mother	Community Member
71	Madonna Odey	F	Ekumtak	Ogoja	New mother	Community Member
72	Cecilia Godwin	F	Ekumtak	Ogoja	New mother	Community Member
73	Veronica Simon	F	Ekumtak	Ogoja	New mother	Community Member
74	Regina Nku	F	Ekumtak	Ogoja	New mother	Community Member
75	Agness Odey	F	Ekumtak	Ogoja	New mother	Community Member
76	Odu Justine Alanke	F	Ekumtak	Ogoja	WDC	Member/ TBA
77	Joseph Buvem	M	Ekumtak	Ogoja	WDC	Member
78	John J. Abuo	M	Ekumtak	Ogoja	WDC	Member
79	Ebuom Elizabeth N.	F	Ekumtak	Ogoja	WDC	Chairperson
80	Augustine Abue	M	Ekumtak	Ogoja	WDC	Secretary
81	Agbor Audu Williams	M	Ekumtak	Ogoja	ETS	Chairman
82	Osang Peter Ojie	M	Ekumtak	Ogoja	ETS	Member
83	Thomas Dante	M	Ekumtak	Ogoja	ETS	Member
84	Bullem Asue	M	Ekumtak	Ogoja	ETS	Member
85	Victor Abuo	M	Ekumtak	Ogoja	ETS	Member

S/N	Name	Sex	Community	LGA	Stakeholder type	Position
86	Shammy Odej	M	Ekumtak	Ogoja	Spouse	Community Member
87	Nku Aju Otu	M	Ekumtak	Ogoja	Spouse	Community Member
88	Monday	M	Ekumtak	Ogoja	Spouse	Community Member
89	Victor Abuo	M	Ekumtak	Ogoja	Spouse	Community Member
90	Agness Abassey	F	Ibil	Ogoja	TBA	Community Member
91	Mojafu Maria	F	Ibil	Ogoja	TBA	Community Member
92	Lydia Idibe	F	Ibil	Ogoja	TBA	Community Member
93	Atim Margaret	F	Ibil	Ogoja	TBA	Community Member
94	Mary Aehu	F	CHC, Ikom	Ikom	Older woman	Community Member
95	Esther George Inyang	F	CHC, Ikom	Ikom	Older woman	Community Member
96	Eseme Ayebe	F	CHC, Ikom	Ikom	Older woman	Community Member
97	Anne Nkang Agbor	F	Ikom	Ikom	TBA	President
98	Getrude Aben	F	Ikom	Ikom	TBA	Member
99	Agness Assimo	F	Ikom	Ikom	TBA	Member
100	Lydia Patrick	F	Ikom	Ikom	TBA	Member
101	Theresa Patrick Hillary	F	Ikom	Ikom	TBA	Member
102	Gbansji Frank	M	Emangabe	Ikom	ETS	Chairman
103	Walter Mofam	M	Emangabe	Ikom	ETS	Member
104	Asigbe Maxwell	M	Emangabe	Ikom	ETS	Member
105	Testimony Eiiah	M	Emangabe	Ikom	ETS	Member
106	Marvellous Nagu	M	Emangabe	Ikom	ETS	Member
107	Chief Ferdinard Asang	M	Emangabe	Ikom	WDC	Chair WDC
108	Pst, Agribe Sylvester N	M	Emangabe	Ikom	WDC	WDC/Clergy
109	Monkom Miracle	M	Emangabe	Ikom	WDC	WDC
110	Modey Vivian Ushama	F	Emangabe	Ikom	First time mother	Community Member
111	Faith Eba Nkepecal	F	Emangabe	Ikom	First time mother	Community Member
112	Atila Marian Koko	F	Emangabe	Ikom	First time mother	Community Member
113	Akong Comfort	F	Emangabe	Ikom	First time mother	Community Member

S/N	Name	Sex	Community	LGA	Stakeholder type	Position
114	Alul Maureen Agbo	F	Emangabe	Ikom	First time mother	Community Member

4. Program Implementers

S/N	Name	Sex	Place	Organization	Position
1.	Regina Ilem	F	Calabar	CHEDRES	Program Officer
2.	Grace Akpan	F	Calabar	CHEDRES	Program Assistant
3.	Felix Ukam	M	Calabar	CHEDRES	EX. Dis
4.	Farouk Jega	M	Calabar	Pathfinder Int	SMGL COP and Pathfinder Country Director
5.	Femi Quaitey	M	Calabar	Pathfinder Int.	SPO
6.	Yemisi Erhunmwunse	F	Calabar	Pathfinder Int.	Senior M&E Technical Advisor
7.	Jaiyeola Olayiwola	M	Calabar	Pathfinder Int.	Senior Technical Manager
8.	Sulaiman Gbadamosi	M	Calabar	Pathfinder Int.	M&EO
9.	Yemisi Femepius	F	Calabar	Pathfinder Int.	Program Mngr
10.	Lauren Dunkwu	F	Calabar	Pathfinder Int.	RA
11.	Kenneth Onyeyose	M	Calabar	Pathfinder Int.	MCLTA
12.	Ifumi Ofere	F	Calabar	Pathfinder Int.	M&EO
13.	Arogundade Kazeem	M	Calabar	Pathfinder Int.	SPO
14.	Jimmy Eko	M	Calabar	Pathfinder Int.	PI
15.	Aondowase Isavgb	M	Calabar	Pathfinder Int.	Driver
16.	Ikpeme Patricia	F	Calabar	Pathfinder Int.	SPO
17.	Jack Biboyanaba	F	Calabar	Pathfinder Int.	PO
18.	Alobi Ntinka	F	Calabar	Pathfinder Int.	SPO
19.	Opeyemi Omilabu	M	Calabar	Pathfinder Int.	Fin & Admin
20.	Blessing China-Cheongi	F	Calabar	Pathfinder Int.	Admin Coord.
21.	Ojo Ademola	M	Calabar	Pathfinder Int.	Account&Admin
22.	Sunday Ogenyi	M	Calabar	Pathfinder Int.	Admin
23.	Emenike Promise	F	Calabar	Pathfinder Int.	MEL PO
24.	Eberechukwu Eke	M	Calabar	Pathfinder Int.	SPO
25.	Omole Obafemi	M	Calabar	Pathfinder Int.	SPO
26.	Godson Nwanfukwu	M	Calabar	Pathfinder Int.	AAC
27.	Dr Mabel I. Ekote	F	GH, Calabar	SOGON	State Coordinator
28.	Dr Nelson Egwu	F	GH, Calabar	SOGON	Senior Reg
29.	Eberechukwu Eke	M	Calabar	Pathfinder Int.	SPO
	Omole Obafemi	M	Calabar	Pathfinder Int.	SPO
	Jack Bibayangba	F	Calabar	Pathfinder Int.	PO
	Ikpeney Patricia	F	Calabar	Pathfinder Int.	SPO

5. State and Federal Government Health Officials and Members of Medical Societies

S/N	Name	Sex	Organization	Position
1	Dr. Inyang Asibong	F	CRS Ministry of Health	Commissioner of Health (former)
2	Dr. Joseph Bassey	M	CRS Ministry of Health	Permanent Secretary
3	Dr.Essien Itam	M	CRS Ministry of Health	Director of Medical Services
4	Mr. Bassey Effiong	M	CRS Ministry of Health	M& E focal person MOH
5	Lucy Enakhirerhi	F	CRS Ministry of Health	Family Planning Coordinator
6	Nsa Ita Eyo	F	CRS Ministry of Health	Safe Motherhood Coordinator
7	Dr. Essei	M	CRS Ministry of Health	Desk Officer for MPDSR
7	Dr. Betta Edu	M	CRS Ministry of Health	Director General
8	Sally Enyim	F	CRS Ministry of Health	Reproductive Health Coordinator
9	Joy Chabu	F	CRS PHCDA	FP Coordinator
10	Edward Okadie Aleje	M	CRS PHCDA	M & E focal person
11	Agnes Ogogo	F	CRS PHCDA	Social Mobilization Officer
12	Dr./Prof. Mabel Ekott	F	SOGON	Coordinator of CRS Chapter
13	Dr. Emmanuel Adams	M	NISONM	Coordinators
14	Dr. Dan Abubaker	M	AGPMPN	President
15	,Dr.Chigozie Nzomba	M	NISOMNM	National Coordinator
16	Dr. Samuel Oyeneiyi	M	Federal MoH	Assistant Director RH (MH) and MPDSR Coordinator
17	Dr. Dr. Kayode Afolabi		Federal MoH	Director of Reproductive Health Division

6. Monitoring and Evaluation Specialists

S/N	Name	Sex	Organization	Position
1	Olufolake Akeju	F	DEVTECH	Senior M&E Officer
2	Mukhtar Ijaiya	M	DEVTECH	M&E Officer
3	Toyosi	M	DEVTECH	Database Officer
4	Yemisi Erhunmwunse	F	Pathfinder Nigeria	Senior Technical Advisor,
7	Kenneth Onyejose	M	Pathfinder Nigeria - Calabar	Senior MEL Program Officer
8	Ifumi Ofere	F	Pathfinder Nigeria - Calabar	MEL Program Officer
9	Praise Emenike	F	Pathfinder Nigeria - Calabar	MEL Program Officer
10	Mr. Etu Francis Uno	F	Gen. Hospital Ugep	HOD Records
11	Mrs. Enya Arit Ideba	F	Gen. Hospital Ugep	Chief Health Records Technologist and Facility M&E Officer
12	Magusta Okpa Udop	F	PHC Ikot Nakanda, Akpabuyo	PCHEW1/M&E Focal Person
13	Rebecca Nkanu Ubi	F	PHC Idomie, Yakurr	PCHEW
14	Achong Margaret Bushang	F	PHC Idomie, Yakurr	PCHEW

S/N	Name	Sex	Organization	Position
15	Christiana Bassey Essien	F	PHC Idundu Akpabuyo	PCHEW and M&E Officer
16	Rose Bassey Effanga	F	ST Joseph Hospital, Akpabuyo	Chief Health Records Technician (CHRT) (M&E)
17	Mrs Rose Okon Mbukpa	F	ST Joseph Hospital, Akpabuyo	Assistant Chief Health Records Technician (CHRT) (M&E)
18	Miss Lovelyn Olofu Agbor	F	ST Joseph Hospital, Akpabuyo	Health Record Assistant
19	David Oyira	M	Ansor Clinic, Yakurr	M&E/Administrator
20	Mauri Esu Enem	F	Ansor Clinic, Yakurr	Community Health Worker
21	Ofem Nelson Ekpo	M	Ansor Clinic, Yakurr	M&E
22	Helen Eban Dermot	F	Catholic Maternity Hospital Moniaya Ogoja	Facility M&E Officer
23	Mrs Sylvia Moses-Mary Obi	F	General Hospital Ogoja	HOD (M&E), Health Information Department
24	Ibi Uratu	M	Holy Family Catholic Hospital Ikom	Holy family catholic hospital Ikom
25	Okonkwo Josephine Ijeoma	F	Comprehensive Health Centre (CHC), Ikom	NPower M&E Officer,
26	Janet Nkpontey	F	PHC Emangabe, Ikom	CHEW
27	Elle Doris Mogi	F	PHC Ekumtak Mbube, Ogoja	CHEW
28	Mrs Evelyn Abubang	F	Melrose Hospital (Private Hospital), Ikom	M&E Officer,

ANNEX V. DISCLOSURE OF ANY CONFLICTS OF INTEREST

GLOBAL HEALTH PROGRAM CYCLE IMPROVEMENT
PROJECT

USAID NON-DISCLOSURE AND CONFLICTS AGREEMENT

USAID Non-Disclosure and Conflicts Agreement- Global Health Program Cycle Improvement Project

As used in this Agreement, Sensitive Data is marked or unmarked, oral, written or in any other form, "sensitive but unclassified information," procurement sensitive and source selection information, and information such as medical, personnel, financial, investigatory, visa, law enforcement, or other information which, if released, could result in harm or unfair treatment to an individual or group, or could have a negative impact upon foreign policy or relations, or USAID's mission.

Intending to be legally bound, I hereby accept the obligations contained in this Agreement in consideration of my being granted access to Sensitive Data, and specifically I understand and acknowledge that:

1. I have been given access to USAID Sensitive Data to facilitate the performance of duties assigned to me for compensation, monetary or otherwise. By being granted access to such Sensitive Data, special confidence and trust has been placed in me by the United States Government, and as such it is my responsibility to safeguard Sensitive Data disclosed to me, and to refrain from disclosing Sensitive Data to persons not requiring access for performance of official USAID duties.
2. Before disclosing Sensitive Data, I must determine the recipient's "need to know" or "need to access" Sensitive Data for USAID purposes.
3. I agree to abide in all respects by 41, U.S.C. 2101 - 2107, The Procurement Integrity Act, and specifically agree not to disclose source selection information or contractor bid proposal information to any person or entity not authorized by agency regulations to receive such information.
4. I have reviewed my employment (past, present and under consideration) and financial interests, as well as those of my household family members, and certify that, to the best of my knowledge and belief, I have no actual or potential conflict of interest that could diminish my capacity to perform my assigned duties in an impartial and objective manner.
5. Any breach of this Agreement may result in the termination of my access to Sensitive Data, which, if such termination effectively negates my ability to perform my assigned duties, may lead to the termination of my employment or other relationships with the Departments or Agencies that granted my access.
6. I will not use Sensitive Data, while working at USAID or thereafter, for personal gain or detrimentally to USAID, or disclose or make available all or any part of the Sensitive Data to any person, firm, corporation, association, or any other entity for any reason or purpose whatsoever, directly or indirectly, except as may be required for the benefit USAID.
7. Misuse of government Sensitive Data could constitute a violation, or violations, of United States criminal law, and Federally-affiliated workers (including some contract employees) who violate privacy safeguards may be subject to disciplinary actions, a fine of up to $5,000, or both. In particular, U.S. criminal law (18 USC § 1905) protects confidential information from unauthorized disclosure by government employees. There is also an exemption from the Freedom of Information Act (FOIA) protecting such information from disclosure to the public. Finally, the ethical standards that bind each government employee also prohibit unauthorized disclosure (5 CFR 2635.703).
8. All Sensitive Data to which I have access or may obtain access by signing this Agreement is now and will remain the property of, or under the control of, the United States Government. I agree that I must return all Sensitive Data which has or may come into my possession (a) upon demand by an authorized representative of the United States Government; (b) upon the conclusion of my employment or other relationship with the Department or Agency that last granted me access to

Sensitive Data; or (c) upon the conclusion of my employment or other relationship that requires access to Sensitive Data.

9. Notwithstanding the foregoing, I shall not be restricted from disclosing or using Sensitive Data that: (i) is or becomes generally available to the public other than as a result of an unauthorized disclosure by me; (ii) becomes available to me in a manner that is not in contravention of applicable law; or (iii) is required to be disclosed by law, court order, or other legal process.

ACCEPTANCE

The undersigned accepts the terms and conditions of this Agreement.

Deborah A. Caro	1/31/2019
Signature	Date
Deborah A. Caro	Co-Director
Name	Title

Sensitive Data; or (c) upon the conclusion of my employment or other relationship that requires access to Sensitive Data.

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ACCEPTANCE

The undersigned accepts the terms and conditions of this Agreement.

AdeyemAO — 25 Jan 2019

Signature — Date

Adedayo Adeyemi. — Consultant

Name — Title

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ACCEPTANCE

The undersigned accepts the terms and conditions of this Agreement.

Signature [redacted] Date 17/02/19

Name Adeyeye Peter Title Mr.

Sensitive Data; or (c) upon the conclusion of my employment or other relationship that requires access to Sensitive Data.

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ACCEPTANCE

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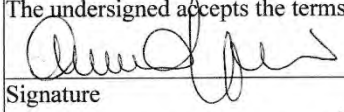
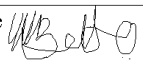
	18th Dec 2018
Signature	Date
ANNA AFFERRI	R MNCH Specialist
Name	Title

Sensitive Data; or (c) upon the conclusion of my employment or other relationship that requires access to Sensitive Data.

9. Notwithstanding the foregoing, I shall not be restricted from disclosing or using Sensitive Data that: (i) is or becomes generally available to the public other than as a result of an unauthorized disclosure by me; (ii) becomes available to me in a manner that is not in contravention of applicable law; or (iii) is required to be disclosed by law, court order, or other legal process.

ACCEPTANCE
The undersigned accepts the terms and conditions of this Agreement.

Signature  Date 12/07/18

Name Mohammed Bello Title Mr.

ANNEX VI. SUMMARY BIOS OF EVALUATION TEAM

Deborah Caro, team leader, is a social development, gender equality, and RH specialist with 25 years of technical leadership for USAID, NGOs, UNFPA, PAHO, and Foundation programs in the areas of FP, MNH, HIV/AIDS, gender-based violence, gender integration and mainstreaming, M&E, rural development, environment, economic growth, WASH, service delivery, and research. She has 15 years of progressive senior project leadership and management experience with a worldwide focus on gender issues. Her work includes policy and programmatic applications of socio-cultural research findings, expertise in health, gender analysis, rural development, nutrition, food security, and strategic planning. Ms. Caro served as team leader for three major safe motherhood programs, Averting Death and Disability, the Initiative for Maternal Mortality Program Assessment, the Health Services Project (Indonesia), and Fistula Care. She also led an initiative to develop strategic guidelines for integrating attention to gender equality and women's empowerment in the Bill and Melinda Gates Foundation's MNCH, RH/FP, and Nutrition Teams' global development grants. She is acknowledged for collaborative program planning, implementation, and monitoring and evaluation with donors, host-country government officials, NGOs, and community groups. She has a Ph.D. and M.A. in anthropology from the Johns Hopkins University and a B.A. from Cornell University.

Adedayo Adeyemi, evaluation specialist, is a statistical epidemiologist, evaluation specialist, and survey statistician with more than 20 years progressive work experience. He has programmatic experience in maternal and child health, HIV, tuberculosis and malaria prevention, treatment, and research. He has provided technical support to Government of Nigeria in HIV/AIDS data availability, quality and reporting, and was instrumental to the development of National HIV Monitoring and Evaluation Plan 2011 – 2016, Nigeria Global AIDS Response Progress Reports, and revision of national HIV/AIDS tools. He has a medical degree from the of Ilorin Nigeria, a Master of Public Health from Harvard University, a Postgraduate Diploma in Clinical Trials from University of London/London School of Hygiene and Tropical Medicine, and a Doctor of Philosophy in Medical Research supervised in the Department of Statistics in Ludwig-Maximilians- University of Munich Germany, and Master of Science degree in Medical Statistics from London School of Hygiene and Tropical Medicine.

Peter Adeyeye, logistics coordinator, is a development professional with cross-cutting experience in program design and implementation, logistics coordination, project management, and policy analysis with an interest in evidence-based development interventions geared towards improved quality of life in Nigeria and sub-Saharan Africa. He is currently Program Manager at Boundless Hands Africa Initiative for Women and Children and was previously Program Analyst at the Centre for Public Policy Alternatives, Lagos. He participated in the Brown International Advanced Research Institute at Brown University and has an MSc in sociology from the University of Lagos.

Anna Afferri, RMNCH specialist, is a UK-based maternal child health and nutrition specialist with more than 20 years of experience in Africa, Asia, and the Caribbean. She earned a Master in Public Health at the Institute of Tropical Medicine in Antwerp and a Master in Humanitarian Assistance in Rome. Recently, she earned a post-graduate in International Health Consultancy at the Liverpool School of Tropical Medicine. Md. Afferri has significant experience in managing, implementing, and monitoring nutrition-focused programs in Haiti, Chad, Liberia, Sierra Leone, DRC, and Uganda. and has also worked

in Gabon, Tibet, Algeria, and Angola in maternal and infant health programs. As MCHN specialist, she took part at different finals evaluations for USAID; as sexual and RH specialist, she undertaken curricula development and training evaluations. Her consultancy work has resulted in an assortment of publications, including program proposals, evaluation reports, and training manuals. She has experience in the development of specific primary healthcare and institutional capacity strengthening programs. She has worked for a range of donors including USAID, IDB, ECHO, UNHCR, and UNICEF and with both international NGOs and private consulting firms.

Mohammed Bello, local evaluator, is a development consultant with more than seven years' experience. He has worked with national and international organizations, including WYG United Kingdom, Gender Research Alliance (GRA) South Africa in the delivery of varying development evaluations, programs, and projects supported by DFID, USAID, International Labour Organization, Deutsche fur International Zusammenarbeit, and government institutions in Nigeria, while mainstreaming gender. His expertise includes M&E, baseline surveys and assessments, coalition building and advocacy, gender mainstreaming, support and development; training, general project design, implementation, support and management. He is currently Chief Executive Officer at the African Centre for Innovative Research and Development in Kano State.

Emilia Okon, local gender expert, is a result-oriented development practitioner with more than 10 years' experience. She has occupied several positions with organizations and youth affiliations at state and national level to conceptualize, design, plan and implement different projects in Nigeria. Her areas of expertise are gender, sexual and reproductive health and rights, HIV/AIDS, life management skills and entrepreneurship and business development.

For more information, please visit

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